



GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD MEETING AGENDA

State of California DEPARTMENT OF HEALTH CARE SERVICES

Notice is hereby given that the **Global Medi-Cal DUR Board** will conduct a public meeting on **Tuesday, November 27, 2018**, at the following location:

Department of Health Care Services
1700 K Street
1st Floor Conference Room
Sacramento, CA 95814

[Registration link](#) to attend meeting via webinar

9:30 AM-3:00 PM

Report Type*	Agenda Item	Presenter	Time
C	1. Welcome/Introductions	Pauline Chan, RPh, MBA	930-940
A/D	2. Call to Order/Guidelines	Andrew Wong, MD	940-945
I/D	3. Presentation: Review of Robert's Rules	Pauline Chan, RPh, MBA	945-1000
A/D	4. Review and Approval of Previous Minutes from September 18, 2018	Andrew Wong, MD	1000-1005
	5. Old Business		
I/D	a. Review of Board Action Items from September 18, 2018	Pauline Chan, RPh, MBA	1005-1010
I/D	b. Recommended Action Items for MCPs from September 18, 2018	Pauline Chan, RPh, MBA	1010-1015
A/D	c. Automatic Refill	Vic Walker, RPh	1015-1025
Morning Break			1025-1035
A/D	d. Global DUR Board Priorities	Andrew Wong, MD	1035-1130
	6. New Business		
A/D	a. DUR Board Activities <ul style="list-style-type: none"> i. Vice Chair Election ii. Discussion of Vice Chair Election Process 	Andrew Wong, MD	1130-1140
R/A/D	b. Presentation: Reimbursement Changes for Covered Outpatient Drugs for Fee-For-Service Medi-Cal Pharmacy Providers	Trudi Balestreri, MBA, PMP	1140-1200
Lunch Break			1200-100

R/A/D	c. Retrospective DUR <ul style="list-style-type: none"> i. Review of Retrospective DUR Criteria: New Additions to the Medi-Cal List of Contract Drugs (FFY 2017) ii. Review of Retrospective DUR Criteria: Hepatitis C Virus (HCV) Drugs 	Shalini Lynch, PharmD	100-130
R/A/D	<ul style="list-style-type: none"> iii. Quarterly Report: 3Q2018 (July – September 2018) iv. Review of FFS Physician Administered Drugs (PADs): 2Q2018 (April – June 2018) v. Discussion: DUR Data Reports 	Amanda Fingado, MPH	130-150
R/A/D	d. Review of DUR Publications <ul style="list-style-type: none"> i. Alert (September 2018): CURES Requirements ii. Bulletin (September 2018): Immunization Update iii. Discussion/Recommendations for Future Bulletins 	Shalini Lynch, PharmD	150-155
Afternoon Break			155-205
R/A/D	e. Prospective DUR: Fee-for-Service <ul style="list-style-type: none"> i. New GCNs for 3Q2018 (July – September 2018) ii. Therapeutic Duplication (TD) Alert f. DUR Educational Outreach to Providers: Fee-for-Service <ul style="list-style-type: none"> i. Outcomes: MEDD 	Amanda Fingado, MPH	205-220
R/I/A/D	g. Pharmacy Update <ul style="list-style-type: none"> i. Prescription Drug Overdose Prevention Initiative ii. Smart Care California iii. Naloxone iv. Drug Take-Back Service v. Six Building Blocks vi. Million Hearts 2022 vii. Medi-Cal Populations viii. CMS DUR Annual Report 2018 h. Recap of today's action items i. Looking ahead: Call for future meeting agenda topics	Pauline Chan, RPh, MBA	220-250
C	7. Public Comments **		250-300
I	8. Consent Agenda		
	a. Meeting feedback b. Next meeting: February 26, 2019 1700 K Street 1 st Floor Conference Room Sacramento, CA 95814 c. Proposed DUR Board Meeting Dates for 2019: Tuesday, May 21, 2019 Tuesday, September 17, 2019 Tuesday, November 19, 2019		
	9. Adjournment		300

* REPORT TYPE LEGEND: **A: Action; R: Report; I: Information; C: Comment; D: Discussion**

** Comments from the public are always appreciated. However, comments will be limited to five minutes per individual.

Picture identification is required to gain access into the California Department of Health Services building. However, your security information will not be provided to the Global DUR Board.

You can obtain the Global DUR Board agenda from the Medi-Cal DUR Main Menu Web site (http://files.medi-cal.ca.gov/pubsdoco/dur/dur_home.asp).



**GLOBAL MEDI-CAL DUR BOARD MEETING
PACKET SUMMARY
November 27, 2018**

- **Suggested Sections to Review Prior to Meeting**
 - Presentation: Review of Robert's Rules (**Pages 5 – 7**)
 - Moving forward there will be a closer adherence to Robert's Rules of Order during DUR Board meetings. Refresh your knowledge with the attached information.
 - Global DUR Board Priorities (**Pages 25 – 32**)
 - We will be continuing the discussion regarding the DUR Board priorities. Please review the topics and the proposed vital directions for DUR.
 - Discussion: DUR Data Reports (**Pages 59 – 60**)
 - There is a proposal to update the standard DUR reports presented at each Board meeting, in order to provide more useful reports to the Global Medi-Cal DUR Board. Take a look and see what is being proposed. Are there additional standard, templated reports you are interested in that you don't see listed?
- **Important Reminders**
 - The following tentative dates for the 2019 DUR Board meetings have posted:
 - Tuesday, February 26, 2019
 - Tuesday, May 21, 2019
 - Tuesday, September 17, 2019
 - Tuesday, November 19, 2019

Global Medi-Cal DUR Board General Meeting Guidelines

- Be familiar with the [Bagley-Keene Open Meeting Act](#)
- Be familiar with [Robert's Rules of Order](#)
- Be courteous, respectful, and open minded of other's comments
- Be prepared by reviewing materials and downloading documents on PC/tablet in advance



Robert's Rules of Order

A Refresher
November 27, 2018



Robert's Rules of Order

Purpose:

- Support an orderly and democratic decision process
- Facilitate group decisions

Motion:

- A member presents a formal proposal requesting the group to take a certain action or position
- A main motion is required to begin the decision making process
- A motion occurs prior to discussion



Robert's Rules of Order -2

Quorum

- There is a quorum when the majority of the members are present

Vote

- Majority = more than half of the votes cast by persons entitled to vote, excluding absence or abstentions



The Main Motion Process

- 1
 - Member makes a **clearly worded motion to take action on a position**.
 - "I moved.....". Motion recorded in minutes.
- 2
 - **Motion must be seconded.** A motion without a second does not move forward.
 - "Second!" A second allows discussion to occur; it does not signify approval.
- 3
 - **Chairperson restates the motion.** This provides clarity.
 - "It is moved and seconded that....."
- 4
 - **Discussion/debate occurs.** : "Is there a discussion?"
 - Maker of motion starts discussion
 - Amendments may be offered – return to step 1 to amend motion: "I move to amend the motion by....."
- 5
 - Chairperson closes discussion and **states the question/asks for a vote**.
 - "The question is on the adoption of the motion that...."(Repeat the motion word for word)
- 6
 - **Chairperson provides voting directions:** "Those in favor of the motion. Say aye", "those oppose, say no".
- 7
 - **Chairperson announces the result of the vote:** The "ayes have it, and the motion is adopted" or "the noes have it, and the motion is lost". Recorded in minutes.



What to Say....

Purpose	Motion	Say	Debate Allowed	Vote Required
Introduce business	Main	"I move that..."	Yes	Majority
Second a Motion	Second	"Second"	No	No
Change the wording/ clarify a motion	Amend	"I move to amend the motion by..."	Yes	Majority
Postpone action until a specific time	Postpone	"I move the motion be postponed until..."	Yes	Purpose
Take break	Recess	"I move to recess for (x) minutes"	No	Majority
Close meeting	Adjourn	"I move to adjourn"	No	Majority

Contents adopted from Robert's Rules of Order Cheat Sheet from www.umecca.com



Questions?





**GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) BOARD
MEETING MINUTES**

Tuesday, September 18, 2018

9:30 a.m. – 3:00 p.m.

**Location: Department of Health Care Services (DHCS)
1700 K Street, 1st Floor Conference Room
Sacramento, CA 95814**

Topic	Discussion
1) CALL TO ORDER/ WELCOME/ INTRODUCTION	<ul style="list-style-type: none"> The Global Medi-Cal Drug Use Review Board (the "Board") members and meeting attendees introduced themselves. Pauline Chan, RPh (DHCS) gave a special introduction to Ivana Thompson, PharmD, who is the new Chief of the Pharmacy Operations Branch at DHCS. Ms. Chan let the group know that Dr. Thompson had prior experience with the DUR Board, as a former DUR pharmacist. Board members present: Drs. Timothy Albertson, Michael Blatt, Chris Chan, Lakshmi Dhanvanthari, Stan Leung, Johanna Liu, Janeen McBride, Yana Paulson, Randall Stafford, Marilyn Stebbins, Andrew Wong, Iris Young, and Vic Walker. Board members absent: Drs. Jose Dryjanski, Robert Mowers, and Ramiro Zuniga. Additional DHCS staff present included Mike Wofford, PharmD, Dorothy Uzoh, PharmD, Paul Nguyen, PharmD, Paul Pontrelli, PharmD, Marco Gonzales, PharmD, and Orlanda Bratlien. Representatives present from other Medi-Cal managed care plans (MCPs) included Matthew Garrett, PharmD (Health Plan of San Joaquin), Kristen Tokunaga, PharmD, BCGP (Health Plan of San Joaquin), Lisa Ghotbi, PharmD (San Francisco Health Plan), Jessica Shost, PharmD (San Francisco Health Plan), Helen Lee, PharmD, MBA (Alameda Alliance for Health), and Adam Horn (CenCal Health). The Chair of the Board, Dr. Andrew Wong, called the meeting to order. Dr. Wong stated that he is viewing an electronic copy of the agenda and packet in order to follow the agenda and attachments being presented. He explained that any Board members using personal computing devices during the meeting are viewing the same materials provided to the public. This statement is required by Open Meeting rules.
2) REVIEW AND APPROVAL OF MINUTES FROM MAY 22, 2018 AND PROPOSED MEETING GROUND RULES	<p>The Board reviewed the minutes from the Board meeting held on May 22, 2018. Dr. Wong stated he had a few minor edits. Dr. Albertson motioned that the minutes be approved with Dr. Wong's edits. The motion was seconded. There was no discussion. The Board voted unanimously to approve the minutes.</p> <p>AYE: Albertson, Blatt, Chan, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Young NAY: None ABSTAIN: None ABSENT: Dhanvanthari, Dryjanski, Mowers, Zuniga</p> <p>ACTION ITEM: Incorporate Dr. Wong's edits into the May 22, 2018 minutes and post to the DUR website.</p> <p>Dr. Wong then proposed Board meeting ground rules to the Board for their review and</p>

	<p>consideration.</p> <p>The proposed meeting ground rules include:</p> <ul style="list-style-type: none"> • Be familiar with the Bagley-Keene Open Meeting Act • Be familiar with Robert's Rules of Order • Be courteous, respectful, and open minded of other's comments • Be prepared by reviewing materials and downloading documents on PC/tablet in advance <p>Dr. Wong explained that if approved, these rules would be reviewed at the beginning of each Board meeting and would be included in the Board Member Orientation Manual. He stated that they are subject to revision, as needed.</p> <p>Dr. McBride suggested that the Board follow Robert's Rules of Order more closely and conduct discussion on a motion, not on the presentation. Dr. Stafford also suggested clarifying the role of public comment during the Board meetings. Ms. Chan stated that according to the DUR by-laws, there is 5-10 minutes allowed for public comment at the end of the session at the podium with an open microphone available. Dr. Ghotbi asked for the Board to consider public comment before voting on motions, especially from MCP representatives if the motion will have an impact on MCPs. Dr. Wong agreed he would like to hear from plan representatives before votes and asked how the Board could get comments from MCPs. Ms. Chan stated that there is a podium available for MCP representatives to comment during the meeting and, in addition, the webinar is open for comments from MCP representatives attending via webinar.</p> <p>Dr. Wong proposed changing the title from meeting ground rules to general meeting guidelines. Dr. Stafford motioned to approve with the title change suggested by Dr. Wong. The motion was seconded. There was no further discussion. The Board voted unanimously to approve the general meeting guidelines.</p> <p>AYE: Albertson, Blatt, Chan, Dhanvanthari, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Young NAY: None ABSTAIN: None ABSENT: Dryjanski, Mowers, Zuniga</p> <p>ACTION ITEM: The DUR Board recommendation to approve the Global Medi-Cal DUR Board General Meeting Guidelines will be submitted to DHCS.</p>
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3) OLD BUSINESS	<p>a. Review of Action Items from Previous Board Meeting:</p> <ol style="list-style-type: none"> Automatic Refill Policy – to be discussed today FFY2017 DUR Annual Report – submitted May 30, 2018 FFY2018 DUR Annual Report Companion Guide/FAQ – to be discussed today Priority Order of Prospective DUR Alerts – to be discussed today CCS/GHPP Drug Utilization Review – to be discussed today Pharmacy Reimbursement Policy – to be discussed today DUR Educational Bulletin: Naloxone – approved as topic; added to the queue 2018 – 2019 Board Priorities – to be discussed today DUR Educational Outreach to Pharmacies: NRT – to be discussed today DUR Educational Outreach to Providers: Opioids – to be discussed today <p>b. Recommended Action Items for MCPs – Ms. Chan presented the action items for MCPs from the Board meeting on May 22, 2018.</p>
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4) NEW BUSINESS	<p>a. Global DUR Board Activities</p> <ol style="list-style-type: none"> DUR Priorities: Survey Results Before voting on top priorities, Dr. Wong reviewed the DUR topics that were proposed at the last meeting. Dr. Stebbins had concern that some of the topics are outside the purview of the Board and stated that we should not set priorities for things we cannot
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achieve. Dr. Wong suggested these topics might help convey what is important to the Board within the context of the DHCS quality initiatives. Dr. Stebbins questioned how these priorities might impact the Board goals.

Ms. Chan stated that the Global Medi-Cal DUR Board was, in part, created for DHCS to learn what the MCPs are working on and what they viewed as priorities. She stated that DHCS would like to embrace what is important to the health plans and speak of issues relevant to the entire Medi-Cal population.

Dr. Ghotbi noted that she reviewed the materials in advance, and it appears the survey has already been conducted and results have been posted. She wondered if new priorities were being discussed. Ms. Chan replied that the survey had already been conducted and results had already been tabulated, with these results included in the posted packet. A review of the Bagley-Keene Open Meeting Act was conducted after the packet had posted, and it was determined that all voting by the Board needs to take place during public meetings and not outside the meeting.

Dr. Stafford stated that he is coming from the priority process from a different perspective. He stated that as a primary care provider and academic researcher, he feels that topics of priority should be relevant to the physicians providing care. As his exposure to DUR issues comes entirely through disease management, he sees disease management as relevant to drug utilization. He noted that academic research suggests ways that the system isn't working, with recognition of this requiring alignment of this group with other efforts and aligning the physician population with the DUR program.

Dr. Wong asked for more information on topics that Dr. Stebbins thought did not fit with the mission of the DUR program. Dr. Stebbins gave examples, including how intravenous acetaminophen in the hospital is not an outpatient drug and not all plans have beneficiaries enrolled in CCS. She also stated that specialty pharmacy might fit differently for each plan, and that value-based purchasing and Car-T may also be outside the scope of DUR. Dr. Wong agreed that many of the topics she mentioned could be excluded. Dr. Young stated that the discussion last time addressed intravenous administration of acetaminophen. Dr. Stebbins wondered if inpatient therapy was an issue for plans that are not in an integrated system.

Dr. Albertson stated that we've addressed some of these topics already on the fringes, such as asthma and we could/should look at hypertension and diabetes. He proposed developing some general issues and addressed them globally. He noted some topics couldn't be evaluated with our current data, such as incentives for e-prescribing.

Dr. Stafford suggested that these topics could be clustered into related issues, with distinct clusters that may be of interest to specific groups. Dr. Wong agreed to help consolidate topics into clusters.

Dr. Stafford motioned to table the discussion at this time and consolidate topics for additional review in the afternoon. The motion was seconded. There was no further discussion and the motion passed.

After the lunch break, Dr. Wong and Dr. Stafford presented the slides they worked on with the topics clustered into groups. The four clusters included the following:

- Optimizing Drug Prescribing and Dispensing
- Optimizing Pain Management and Opioids
- Optimizing Chronic Disease Management
- Optimizing Biologics, Specialty Drugs and Cost-effective Care

Dr. Wong suggested each Board member vote for their top two topic clusters. Dr. Wong read the title of each topic cluster and the Board members raised their hand to vote for their top two clusters.

Summary of Board member votes:

- Optimizing Drug Prescribing and Dispensing = 7 votes
- Optimizing Pain Management and Opioids = 6 votes
- Optimizing Chronic Disease Management = 6 votes
- Optimizing Biologics, Specialty Drugs and Cost-effective Care = 7 votes

Dr. Wong suggested that due to time constraints, this topic might need to be revisited at the next Board meeting in November 2018. A motion was made to reassess the DUR Board priorities at the November 2018 DUR Board meeting. The motion was seconded. There was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dhanvanthari, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Young

NAY: None

ABSTAIN: None

ABSENT: Dryjanski, Mowers, Zuniga

ACTION ITEM: The DUR Board recommendation to reassess the DUR Board priorities at the November 2018 DUR Board meeting will be submitted to DHCS.

ii. Automatic Refill

Ms. Chan asked Dr. Wofford to provide background behind the proposed automatic refill policy. While he is aware of potential fraud and abuse of medications that may result from automatic refills, staff has been directed to always consider the patient first. Potential fraud and fiscal impact are secondary to the patient. The Medi-Cal population is huge and many beneficiaries have issues with mental health, home insecurity, frequent moves, and other issues that may affect compliance. The impact of missed medications can be significant for HIV patients, patients with mental health issues, and others. This is why DHCS has been opposed to a blanket removal of the automatic refill. If a pharmacy is willing to do automatic refill, Dr. Wofford proposes that they can ask the patient and set up the auto refill if the patient agrees. Pharmacies could review automatic refill status with the patient at specific time intervals, such as every six months or every year.

Mr. Walker said he feels that every six months or 12 months is reasonable. He thinks every month is too frequent. Dr. Stebbins and Dr. Lee both asked if the automatic refill policy would require patients to opt-in or opt-out. Dr. Wofford states that there is no current Medi-Cal policy on this and is uncertain about State Board of Pharmacy policy on this topic. Dr. Leung stated that the patient should be considered, including what medications and other information on their profile (such as taking antidepressants, for example).

Dr. Young stated that Kaiser doesn't have an auto refill policy but Medicare does, so they follow that policy. Dr. Young suggested that it would be helpful if Medi-Cal policy is not disparate from Medicare policy. Mr. Walker stated he thinks automatic refill should be done with tricyclic antidepressants, while it is less relevant for SSRIs.

Dr. Lisa Ashton (Johnson & Johnson) suggested using the cancel prescription option. She stated that it doesn't need to be set up – just needs to be adopted. This could be part of an outreach program where if a patient fails to pick up their meds, the provider would be notified. Dr. Marco Gonzales (UC Davis) stated that some of the worst pharmacies have patients on polypharmacy with duplicative therapy and it doesn't appear that a pharmacist has ever reviewed the profile. He suggested it would be nice if the pharmacist were required to review the profile and sign off before allowing automatic refill. Dr. Leung stated that other alerts should fire in those cases such as ingredient duplication, therapeutic duplication. Dr. Chan stated that automatic refill doesn't necessarily mean auto shipment and this would impact retail and mail order pharmacies differently. Dr. Wong stated that some medications work well with automatic refill, while others don't.

Ms. Chan asked how the Board would like to proceed. Dr. Wong asked if this topic is ready for a motion or additional discussion. Mr. Walker suggested specifying a time point for review of automatic refill status. Dr. Paulson recommended more discussion and input before a vote. Dr. Paulson motioned to reassess the automatic refill issue at the November 2018 DUR Board meeting. The motion was seconded. There was no further discussion.

AYE: Albertson, Blatt, Chan, Dhanvanthari, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Young

NAY: None

ABSTAIN: None

ABSENT: Dryjanski, Mowers, Zuniga

ACTION ITEM: The DUR Board recommendation to reassess the automatic refill issue at the November 2018 DUR Board meeting will be submitted to DHCS.

- b. Presentation: Leveraging Technology to Address the Opioid Crisis – Linette Scott, MD, MPH, the Chief Medical Information Officer at DHCS described recent technological updates that have either just funded or are currently being used to combat the opioid abuse crisis, including the following:
- Electronic Health Record (EHR) Incentive Program (now referred to as the Promoting Interoperability Program) – funding and incentives provided for demonstrating meaningful use of certified EHR technology
 - Health Information Exchange (HIE) Onboarding Program – enhanced funding is being provided for HIE onboarding for hospitals, physicians/physician practices, and connection to CURES, California’s prescription drug monitoring program database
 - Controlled Substance Utilization Review and Evaluation System (CURES) – recently updated and now can be embedded into the EHR (no longer have to log in separately once embedded)
 - +EMS (Emergency Medical Services) – federal funds were approved in July 2018 to support HIE within Emergency Medical Services (EMS) and to improve transitions of care
 - Patient Unified Lookup System for Emergencies (PULSE) – provides disaster healthcare volunteers with access to electronic health information for victims and evacuees
- c. Health Plan Presentations – Lisa Ghotbi, PharmD and Jessica Shost, PharmD of the San Francisco Health Plan (SFHP) described two initiatives:
- i. 7-Day Limit on Initial Short-Acting Opioid Prescriptions – Dr. Ghotbi and Dr. Shost described how SFHP developed a program to implement a 7-day limit on the initial prescription for short-acting opioids. They described how they used multiple strategies, including academic detailing, developing an FAQ for providers, and creating handouts for members, in order to get buy-in from prescribers. They even worked with their PBM to allow a bypass that was based on provider NPI or if a prior authorization was on file for the initial opioid prescription.
- Dr. Lee stated she is in the middle of implementing a similar program and wondered if the program was implemented in a stepwise fashion or all at once. Dr. Ghotbi stated a tremendous amount of work was done before implementation and warned that while there was initial pushback from surgeons, once they provided evidence-based guidelines and other academic literature to support the policy they ended up having a relatively low number of physicians requesting exemptions.
- ii. Home Blood Pressure Monitor Benefit Extension – Dr. Ghotbi and Dr. Shost summarized an ongoing program at SFHP to learn more about potential barriers to utilization of HBPMs. They discovered barriers exist with regards to pharmacy pricing of HBPM, tracking of patients with HBPMs, and providing sufficient patient training on the use of their HBPM.

Dr. Stebbins commented on the challenges of getting cuffs covered and paid for, with each plan covering a different brand of cuff. She had to create graphs to keep track of every cuff in order to keep an efficient workflow. Dr. Ghotbi suggested that plans should cover many more cuffs to allow the ability to select a specific monitor that will work best for each patient. Agreed it should not be one-size-fits all approach. Amit Khurana, PharmD (Aetna) commented via the webinar that she has noticed prior authorizations for HBPM are starting to come through easier.

- d. Presentation: Million Hearts® Initiative – Desiree Backman, DrPH, MS, RD, DHCS, from the UC Davis Institute for Population Health Improvement and the Chief Prevention Officer at DHCS described how they implemented a quality improvement collaborativeto improve hypertension control and advance Million Hearts® among low-income Californians. She described how DHCS held quarterly webinars with MCPs from January-December 2015 to assist MCPs in sharing best practices and barriers. Through the collaborative MCPs were linked to local, state, and national resources/leaders, internal subject matter experts, and had access to a shared webpage.

The collaborative used the Healthcare Effectiveness Data and Information Set (HEDIS) Controlling High Blood Pressure (CBP) measure, defined as the percentage of members aged 18-85 years who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. CBP data were collected before and after the collaborative.

All participating MCPs had downward trends in CBP rates since 2009. At the baseline assessment in 2014, the CBP weighted average for all plans was 61.2%, and the average CBP rate among the 9 participating MCPs was 56.3% (range 43.1%-69.3%). During the intervention year (2015), 7 of 9 participating MCPs showed statistically significant improvements in CBP rates. The largest improvement was 14.6 percentage points, representing a 33.9% improvement, while the mean improvement was 5 percentage points. During this same time period, there was a decrease from 64.8% to 59.1% for nonparticipating MCPs.

Dr. Backman also shared some contributors to the success of the program, including pay-for-performance to incentivize health centers and provider networks, provider education and outreach, improved data collection to assist in decision-making and practice, and improved patient engagement.

- e. Presentation: AB1114 – Paul Pontrelli, PharmD from DHCS, Pharmacy Benefits Division shared recent developments on Assembly Bill 1114, which authorized selected pharmacy services as a Medi-Cal benefit and allowed reimbursement payments to be paid to pharmacies. He stated that [State Plan Amendment \(SPA\) 18-0039](#) was submitted for federal approval on 9/14/18, with a proposed implementation date of 4/1/19.

f. Prospective DUR: Fee-for-Service

- i. Review of DUR Alerts for New GCNs in 2Q2018 (April – June 2018): At each Board meeting, a list of new GCN additions with prospective DUR alerts turned on other than ER and DD are provided to the Board for review. At this meeting, the Board reviewed the alert profiles of the following GCNs:
- GCN #078238 and #078498: MITOMYCIN – Drug-Pregnancy (PG)
 - GCN #078252: NILOTINIB HCL – Drug-Pregnancy (PG)
 - GCNs #077567, #077568, and #077569: PITAVASTATIN MAGNESIUM – Drug-Pregnancy (PG) and Late Refill (LR)
 - GCN #078131 and #078139: DIPHENHYDRAM/PE/DM/ACETAMIN/GG – Ingredient Duplication (ID), High Dose (HD)
 - GCN #078224: LAMIVUDINE/TENOFOVIR DISOP FUM – Ingredient Duplication (ID)
 - GCN #078254: EFAVIRENZ/LAMIVU/TENOFOV DISOP – Drug-Pregnancy (PG), Ingredient Duplication (ID)
 - GCN #078264: PREDNISOLONE ACETATE/BROMFENAC – Drug-Pregnancy (PG)

- GCN #078286: DUTASTERIDE – Drug-Pregnancy (PG)
- GCN #078077: LEVONORGEST/ETH. ESTRADIOL/IRON – Drug-Pregnancy (PG), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCN #078336: FENTANYL/BUPIVACAINE/NS/PF – Drug Allergy (DA), Drug-Disease (MC), Therapeutic Duplication (TD), Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCN #075279: RITONAVIR – Ingredient Duplication (ID)
- GCN #027229: BACLOFEN – Additive Toxicity (AT)
- GCN #068888: MORPHINE SULFATE/0.9% NACL/PF – Drug Allergy (DA), Drug-Disease (MC), Therapeutic Duplication (TD), Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCNs #078185, #078186, and #078187: AMANTADINE HCL – High Dose (HD), Low Dose (LD)
- GCN #078426: NORTRIPTYLINE HCL – Drug-Disease (MC), Therapeutic Duplication (TD), Late Refill (LR), Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCN #078456: MORPHINE SULFATE – Drug Allergy (DA), Drug-Disease (MC), Therapeutic Duplication (TD), Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCN #078461: ABIRATERONE ACET, SUBMICRONIZED – Drug-Pregnancy (PG)
- GCNs #078432, #078433, #078034, #078435, and #078036: EPOETIN ALFA-EPBX – Drug Allergy (DA), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCN #078481: OMEPRAZOLE – Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCN #078487: TIMOLOL/DORZOLAMIDE/LATANOP/PF – Drug-Pregnancy (PG)
- GCN #078488: DORZOLAMIDE/TIMOLOL/PF – Drug-Pregnancy (PG)
- GCN #078497: TIMOLOL/BRIMONIDIN/DORZOLAM/PF – Drug-Pregnancy (PG)
- GCN #078505: TIMOLOL/BRIMON/DORZO/LATANOP/PF – Drug-Pregnancy (PG)
- GCN #078532 and #078533: OXYCODONE HCL – Drug Allergy (DA), Drug-Disease (MC), Therapeutic Duplication (TD), Additive Toxicity (AT), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
- GCN #067584: HYDROXYUREA – Drug-Pregnancy (PG)
- GCN #078504: TIMOLOL MALEATE/LATANOPROST/PF – Drug-Pregnancy (PG)
- GCN #078477 and #078477: ESTRADIOL – Drug-Pregnancy (PG), Drug-Disease (MC)
- A motion was made – and seconded – to accept these alert profile recommendations. There was no further discussion. The motion was carried.

AYE: Albertson, Blatt, Chan, Dhanvanthari, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Young

NAY: None

ABSTAIN: None

ABSENT: Dryjanski, Mowers, Zuniga

- ii. Alert Priority Order – Ms. Fingado stated that in the current prospective DUR system, when multiple alerts are generated for a prescription they are prioritized by therapeutic problem type according to the following hierarchy:
 1. Drug-allergy conflict (DA)
 2. Drug-pregnancy conflict (PG)
 3. Drug-disease conflict (MC)
 4. Drug-drug interaction (DD) – other pharmacy
 5. Therapeutic duplication (TD)
 6. Overutilization (ER)
 7. Underutilization (LR)
 8. Additive Toxicity (AT)
 9. Ingredient Duplication (ID)

- 10. Drug-age conflict (PA)
- 11. Drug-drug interaction (DD) – same pharmacy
- 12. Incorrect dose (HD/LD/PHD/PLD)

The Board had no questions or suggested changes.

iii. Ingredient Duplication (ID) Alert Update

- EMTRICITABINE – Ms. Fingado stated that when the review of emtricitabine ingredient duplication (ID) alerts was presented at the September 2017 Board meeting the majority of the ID alerts (78%) was due to switch from a regimen containing tenofovir disoproxil fumarate to a regimen containing tenofovir alafenamide. At that time, the Board recommended reviewing these data again in one year to see if regimens had stabilized and the total number of ID alerts had decreased. Ms. Fingado reported that a review of all ID alerts for emtricitabine between July 1, 2017, and June 30, 2018 had been completed. There was a total of 5,528 ID alerts for emtricitabine during this time period, a decrease of 26% when compared to the prior year. Ms. Fingado pointed out a spike in ID alerts after the FDA approved a new drug containing emtricitabine, with 23% of all ID alerts for emtricitabine due to patients switching to the new drug from a different drug containing emtricitabine.
- LITHIUM – Ms. Fingado reported that a review of all March 2018 prospective DUR alerts showed some formulations of lithium are still generating ID alerts, even when neither drug is a 300 mg formulation. A subsequent review in June 2018 revealed the problem was still ongoing, but just for 150 mg tablets. Ms. Fingado reported that as of August 2018, this issue has been fixed for the 150 mg tablets as well.

- iv. Drug-Pregnancy (PG) Alert: Update – Ms. Fingado stated that the Board had recommended an annual review of drug-pregnancy (PG) alert to correct discrepancies. She stated that this annual review of all PG alerts and drugs was very time-consuming, and led to discrepancies when the severity level changed for a drug, especially within the timeframe just following the review. As a result, the PG alert is now on for all drugs (including new GCNs), effective September 2018. There was a precedence for this change with the drug-drug interaction (DD) alert, which has the alert on for all drugs, but alerts are only generated for severity level 1 interactions. An analysis of PG alert volume following the change showed there was no change in the total number of PG alerts generated. Ms. Fingado concluded that this change decreased the potential for errors, saves time, and is more effective at protecting pregnant beneficiaries.

g. DUR Educational Outreach to Providers: Fee-for-Service

- i. Proposal: Additive Toxicity – Ms. Fingado proposed an educational letter to providers regarding the additive toxicity (AT) alert. The learning objectives for this educational letter are as follows:
- To identify beneficiaries at high-risk for adverse events associated with the use of certain opioid medications in combination with benzodiazepines and other CNS depressants
 - To help inform health care providers and patients of the serious risks attributed to co-prescribing of opioids with CNS depressants, including benzodiazepines, non-benzodiazepine receptor agonists, and antipsychotics

The study population would include FFS beneficiaries that generate an AT alert for a combination of opioids, benzodiazepines, and other CNS depressants during a specific month. Prescribers will be sent a packet including patient profiles, the additive toxicity bulletin, information on naloxone, and a provider survey (for each patient). The primary outcome will be the total number of continuously-eligible beneficiaries without active paid claims for both opioids and benzodiazepines six months following the mailing. The secondary outcome will be the total number of continuously-eligible beneficiaries with a paid claim for naloxone within the six months following the mailing.

A motion was made to complete an educational outreach to providers regarding the additive toxicity (AT) alert. There was no further discussion. The motion passed.

AYE: Albertson, Blatt, Chan, Dhanvanthari, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Young

NAY: None

ABSTAIN: None

ABSENT: Dryjanski, Mowers, Zuniga

ACTION ITEM: The DUR Board recommendations to conduct a DUR educational outreach to providers regarding the additive toxicity (AT) alert will be submitted to DHCS.

ii. Outcomes:

- Buprenorphine – Ms. Fingado reported that in 2016, the DUR program sent letters to the top 100 prescribers (by total quantity prescribed) of opioids without a current buprenorphine waiver. Within 12 months, a total of 5 providers completed the training and quantity of opioids prescribed by these providers decreased by 30%. In May 2018 the Board recommended a repeat of the mailing. On August 23, 2018, a total of 100 letters were mailed to top prescribers of opioids (by billed quantity) across all Medi-Cal (includes both FFS and MCP paid pharmacy claims) without a waiver to provide buprenorphine treatment. Final outcomes will be presented at the November 2019 Board meeting.
- NRT – Ms. Fingado reported that while the regulation allowing pharmacists in California to furnish NRT became effective over two years ago, claims data for the Medi-Cal fee-for-service program show limited adoption. On August 23, 2018, a total of 172 letters were mailed to pharmacies with a practice location in one of the top adult smoking rate counties in California, including Colusa, Del Norte, Fresno, Glenn, Lake, Mariposa, Merced, Shasta, Siskiyou, Stanislaus, Tehama, Trinity, Tulare, Tuolumne, and Yuba. Pharmacies were only mailed a letter if they had paid pharmacy claims for at least 100 Medi-Cal beneficiaries (FFS and MCP beneficiaries were included). Final outcomes will be presented at the November 2019 Board meeting.

iii. Updated Outcomes:

- Early Refill – Ms. Fingado reported on the final outcomes of the early refill mailing, which was sent on June 9, 2017. The objectives for this mailing were the following:
 - To assess the feasibility and acceptability of DUR educational outreach letters to pharmacies
 - To decrease the total volume of early refill overrides by pharmacies

The final undeliverable rate was 0% and the final response rate was 29%. The primary outcome showed a 25% decrease in the number of ER alert overrides among the 100 pharmacies who received the mailing, compared with a 4% increase in ER overrides among all other pharmacies who did not receive mailing (n = 5,001). In addition, there was no statistically significant difference in paid claims among the pharmacies that received the letter, so the decrease in ER overrides cannot be attributed to a decrease in claim volume.
- Fluoroquinolones – Ms. Fingado reported on the final outcomes of the fluoroquinolone mailing, which was sent on August 2, 2017. The objectives for this mailing were the following:
 - To inform providers of the FDA-approved safety labeling changes for fluoroquinolones
 - To decrease the number of Medi-Cal patients receiving treatment with fluoroquinolones for acute bacterial exacerbation of chronic bronchitis, acute sinusitis, and uncomplicated UTI

The final undeliverable rate was 15% and the final response rate was 10%. The primary outcome showed a 41% decrease in the number of paid claims for fluoroquinolone among prescribers who received the mailing (n = 85), compared with only a 16% decrease among prescribers who did not receive the mailing (n = 15). A similar difference was also seen among total utilizing beneficiaries, with a 39% decrease in utilizing beneficiaries with a paid claim for a fluoroquinolone observed among those providers who received the letter, compared with only a 5% decrease among providers

who did not receive the letter.

h. Retrospective DUR

- i. Review of FFS Physician Administered Drugs (PADs): 1Q2018 (January – March 2018) – Ms. Fingado showed the Board a summary of paid claims for physician-administered drugs paid through the Medi-Cal FFS program with dates of services between January 1, 2018, and March 31, 2018. These data were presented in three tables: 1) the top 20 drugs by utilizing beneficiaries, 2) the top 20 drugs by total reimbursement paid, and 3) the top 20 drugs by reimbursement paid per utilizing beneficiary.
- ii. Quarterly Report: 2Q2018 (April – June 2018) – Ms. Fingado presented the Medi-Cal fee-for-service quarterly DUR report for the 2nd quarter of 2018, which includes both prospective and retrospective DUR data. For the first time, this quarterly report contains fee-for-service pharmacy utilization data presented in aggregate, by Medi-Cal FFS enrollees only, and by Medi-Cal managed care plan (MCP) enrollees only (includes all carved-out drugs processed through the FFS program. Ms. Fingado also stated that this report now includes Medi-Cal fee-for-service paid claims from all eligible beneficiaries in the Family Planning, Access, Care, and Treatment (Family PACT) program and the California Children's Services/ Genetically Handicapped Persons Program (CCS/GHPP). The Board had several questions regarding the data presented in the new tables. Ms. Fingado stated that this is just the first report that is stratified with these data and she is open to suggestions for improvement.
- iii. Review of FFS CCS/GHPP Drugs (FFY 2017) – Ms. Fingado presented a one-year summary of pharmacy claims data for beneficiaries enrolled in either the California Children's Services (CCS) Program or the Genetically Handicapped Persons Program (GHPP) that had paid pharmacy claims through the Medi-Cal fee-for-service program. These data were presented in three tables: 1) the top 20 drugs by utilizing beneficiaries, 2) the top 20 drugs by total reimbursement paid to pharmacies, and 3) the top 20 drugs by reimbursement paid to pharmacies per utilizing beneficiary. These data had not been presented previously.
- iv. Review of Retrospective DUR Criteria: Hypertension Medication Adherence – Dr. Lynch reviewed the methodology used to measure adherence to hypertension medications and evaluate the use of home blood pressure monitoring (HBPM) devices among Medi-Cal beneficiaries (both FFS and MCP beneficiaries were included). All drug classes listed in the [2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults](#) as either primary or secondary agents were included in the analysis. Adherence to hypertension medication was measured using the proportion of days covered (PDC) method, with a PDC greater than or equal to 80% considered adherent. Pharmacy claims data were evaluated for the calendar year 2017. However, medical claims data were evaluated for a longer time frame (dates of service between January 1, 2012, and December 31, 2017), in order to determine if the frequency of paid claims for HBPM devices has changed over time.

Dr. Lynch reported on the percentage of the population that met the 80% adherent threshold within each separate drug class. Adherence rates were low, ranging from 19.8% of the study population without an ICD-10 code for hypertension that was using potassium-sparing diuretics to a high of 44.7%, which includes the study population with an ICD-10 code for hypertension that was using angiotensin II receptor blockers [ARBs]. Across all drug categories, adherence rates were higher when the beneficiary had a documented ICD-10 code for hypertension. However, adherence rates were low across all categories, even in comparison to other studies that evaluated adherence to antihypertensive in the Medicaid population.

Dr. Ghotbi agreed these rates seemed very low and questioned whether there might be issues with the data analysis. Ms. Fingado stated she would complete additional reviews of the data before publication as part of an educational bulletin.

Dr. Lynch also reported that home blood pressure monitoring device utilization has been increasing steadily over time, however having a paid claim for an HBPM was not correlated with greater adherence to antihypertensive medications. Ms. Fingado noted that this analysis does not include any pharmacy claims for HBPM devices, so these data are incomplete.

- i. Review of DUR Publications presented by Dr. Lynch
 - i. Bulletin (July 2018): Additive Toxicity – Dr. Lynch let the Board know that the DUR educational bulletin entitled, “[ProDUR Update: Additive Toxicity Alert Now Focused Only On CNS Depressants](#)” published in July 2018.
 - ii. Alert (July 2018): Fluoroquinolones – Dr. Lynch let the Board know that the DUR educational alert entitled, “[Drug Safety Communication: Adverse Effects from Fluoroquinolone Antibiotics](#)” published in July 2018.
 - iii. Discussion/Recommendations for Future Educational Bulletins – The calendar for future DUR educational bulletins was reviewed. Dr. Lynch reported that three educational articles are currently in progress: 1) an alert regarding the mandatory CURES consultation requirement; 2) the annual vaccine bulletin; and 3) a bulletin reviewing latent tuberculosis infection (LTBI), including updates to recommended treatment regimen.

In addition, Dr. Lynch also described an update that was made to a clinical recommendation in the QT-Prolongation bulletin, which was published in August 2017. Dr. Paulson motioned that changes to existing bulletins should be brought for discussion to the DUR Board. The motion was seconded. There was no further discussion. The motion passed.

AYE: Blatt, Chan, Dhanvanthari, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Young

NAY: None

ABSTAIN: None

ABSENT: Albertson, Dryjanski, Mowers, Zuniga

ACTION ITEM: The DUR Board recommendation that changes to existing bulletins must be brought for discussion to the DUR Board will be submitted to DHCS.

Dr. Lynch also let the Board know that a disclaimer has been added to the DUR Web page that provides links to the educational articles. The disclaimer specifies that the articles are the result of analyses carried out by the Global Medi-Cal DUR Program and are not official policies of the Department of Health Care Services (DHCS). This disclaimer will also be added to the top of the articles.

Ms. Chan stated that it was determined that sending out educational articles to the entire Board for feedback outside of the public meeting is not in keeping with the guidelines of the Bagley-Keene Open Meeting Act. She proposed that for future articles the Board Chair could assign one or two Board members to review each article. Board members could select topics that are of interest to them or where they have expertise. Dr. Paulson motioned that the DUR Board Chair will assign one or two Board members to review each educational bulletin prior to publication. The motion was seconded. There was no further discussion. The motion passed.

AYE: Blatt, Chan, Dhanvanthari, Leung, Liu, McBride, Paulson, Stafford, Stebbins, Walker, Wong, Young

NAY: None

ABSTAIN: None

ABSENT: Albertson, Dryjanski, Mowers, Zuniga

ACTION ITEM: The DUR Board recommendation that the DUR Board Chair will assign a Board

	<p>member to review each educational bulletin prior to publication will be submitted to DHCS.</p> <p>Ms. Fingado then asked if this process could start with the upcoming LTBI article (the other two articles in progress have already been submitted for publication). Dr. Wong assigned Dr. Albertson and Dr. Leung to review the LTBI article. Dr. Wong stated he would also like to review the bulletin before publication.</p> <p>j. DUR Annual Report to CMS for FFY 2018: Managed Care Survey Questionnaire – Dr. Dhanvanthari and Kristen Tokunaga, PharmD from Health Plan of San Joaquin presented highlights and lessons learned from their experience trying to complete the FFY 2018 DUR Annual Report to CMS. The presentation provided general tips for MCPs and focused on selected questions they found to be more challenging as they completed the report. They incorporated sections from the companion guide that DHCS developed throughout their presentation, creating yet another helpful resource for MCPs as they complete their first report.</p> <p>k. FFY 2018 DUR Annual Report to CMS: Companion Guide/FAQ: Ms. Chan summarized the <i>Medicaid Managed Care Organization Drug Utilization Review Annual Report Companion Guide</i>, which was developed by DHCS to provide guidance and assistance to MCPs in completing their FFY 2018 annual report. Ms. Chan stated that as MCPs begin to work on their reports, she would appreciate any feedback regarding ways to improve the companion guide and any suggestions for additions to the FAQ section located at the end of the guide.</p> <p>l. Pharmacy Update presented by Pauline Chan</p> <ol style="list-style-type: none"> Hepatitis C policy revision – Ms. Chan summarized the updated Treatment Policy for the Management of Chronic Hepatitis C, which became effective July 1, 2018. The notable change to the policy is that it allows treatment to all patients 13 years of age and older with Hepatitis C virus (HCV) infection, regardless of liver fibrosis stage or co-morbidity (with an exception for patients with a life expectancy of less than 12 months). Prescription Drug Overdose Prevention Initiative – Ms. Chan described the statewide overarching strategy for the initiative, which includes safe prescribing, access to treatment, naloxone distribution, a public education campaign, and data informed and driven interventions. She provided the link to the Opioid Overdose Surveillance Dashboard, which includes data from multiple state agencies. Ms. Chan stated that the goals of the initiative include increasing the number of active buprenorphine prescribers, increasing the number of naloxone claims, decreasing all-cause overdose mortality, reducing the concomitant use of benzodiazepines and opioids, and reducing opioid claims > 90 mg MEDD. Academic Detailing – Ms. Chan provided feedback and testimony from participants involved in three academic detailing trainings held recently in California. She also updated the Board on the consensus workshop items developed during the Second Annual DHCS Academic Detailing conference, which was held in October 2017. Dissemination of DUR Educational Bulletins – Ms. Chan provided several recent examples of how MCPs are disseminating the DUR educational bulletins. ADURS Recommended Minimum Standards – Ms. Chan reported that CMS is considering setting minimum standards for Medicaid DUR programs. She also shared the list of recommendations established by the American Drug Utilization Society (ADURS) for both prospective and retrospective DUR. Future meeting agenda topics – Ms. Chan stated that future agenda will include more information about prospective DUR alerts, the pharmacy reimbursement project, CURES, and medication-assisted treatment for opioid addiction. <p>m. Recap of today's action items – Ms. Chan reported that today's action items for managed care health plans would be distributed as soon as possible.</p> <p>n. Looking ahead: Call for future meeting agenda – Ms. Chan requested future meeting agenda items to be shared with her on an ongoing basis.</p>
5) PUBLIC COMMENTS	<ul style="list-style-type: none"> None

6) CONSENT AGENDA	<ul style="list-style-type: none"> The next Board meeting will be held from 9:30 a.m. to 3:00 p.m. on November 27, 2018, in the DHCS 1st Floor Conference Room located at 1700 K Street, Sacramento, CA 95814.
7) ADJOURNMENT	<ul style="list-style-type: none"> The meeting was adjourned at 3:05 p.m.

Action Items	Ownership
Incorporate Dr. Wong's edits into the May 22, 2018 minutes and post to the DUR website.	Amanda
The DUR Board recommendation to approve the Global Medi-Cal DUR Board General Meeting Guidelines will be submitted to DHCS.	Pauline
The DUR Board recommendation to reassess the automatic refill issue at the November 2018 DUR Board meeting will be submitted to DHCS.	Pauline
The DUR Board recommendation to reassess the DUR Board priorities at the November 2018 DUR Board meeting will be submitted to DHCS.	Pauline
The DUR Board recommendations to conduct a DUR educational outreach to providers regarding the additive toxicity (AT) alert will be submitted to DHCS.	Amanda
The DUR Board recommendation that changes to existing bulletins must be brought for discussion to the DUR Board will be submitted to DHCS.	Amanda/ Shal
The DUR Board recommendation that the DUR Board Chair will assign a Board member to review each educational bulletin prior to publication will be submitted to DHCS.	Amanda/ Shal

Board Action Items from September 18, 2018

- General meeting guidelines
 - Approved, now included in new Board member training
- Automatic refill
 - To be discussed today
- New process: review of educational bulletins
 - Approved, selected Board members to review
- New process: changing existing educational bulletins
 - Approved, proposed changes to be brought to Board
- DUR Board priorities
 - To be discussed today
- Educational outreach: additive toxicity alert
 - Letters to be sent January 2019





**GLOBAL MEDI-CAL DRUG USE REVIEW BOARD
SEPTEMBER 18, 2018 BOARD MEETING MCP ACTIONS**

MCP: _____

Name of DUR representative: _____

Summary of Required Actions

- I. Educational Bulletins:** MCP to have a process for distribution of provider education programs and materials developed by Global DUR Board to their providers via established mechanisms.

Required dissemination of DUR educational bulletins and alerts		
Description	Mechanism of dissemination	Date of Dissemination
July 2018 Bulletin: ProDUR Update: Additive Toxicity Alert Now Focused Only On CNS Depressants		
July 2018 Alert: Drug Safety Communication: Adverse Effects from Fluoroquinolone Antibiotics		

**Summary of Global Medi-Cal DUR Board Activities
(not required to document on the Annual Report to CMS)**

1. The FFY 2018 DUR Annual Report to CMS questionnaire has been finalized. The questionnaire was distributed to MCPs at the Pharmacy Directors Meeting on 4/18/18.

Action:

- a. Establish a timeline for review and completion by April 1, 2019.
- b. Review the draft Annual Report Companion Guide and submit questions to DHCS. After "last call" of questions, DHCS is to finalize the Companion Guide to share with all MCPs.

2. Best practices presentation was by San Francisco Health Plan (SFHP) and focused on a seven-day limit on initial short-acting opioid prescriptions. To get buy-in from prescribers, SFHP applied multiple strategies, as follows:

- Organized several academic detailing workshops with providers
- Developed an FAQ for providers and informational handouts for members
- Worked with PBM to allow a bypass based on provider NPI/prior authorization

Action:

- a. MCP to evaluate above strategies and apply as appropriate.

3. A second best practice presentation (also by SFHP) focused on home blood pressure monitoring. They identified several potential barriers to utilization of HBPMs:

- Pricing issues
- Inadequate patient tracking system
- Inadequate patient training on HBPM use

Action:

- a. MCP to evaluate HBPM policies and utilization and to address potential barriers.

4. There was also a presentation on the Million Hearts® Initiative by Dr. Desiree Backman. She led a DHCS collaborative with MCPs from January-December 2015 to assist MCPs to improve hypertension control. The following were identified as contributors to the success of the collaborative:

- Pay-for-performance to incentivize health centers and provider networks
- Provider education and outreach
- Improved data collection to assist in decision-making and practice
- Improved patient engagement

Action:

- a. MCP to follow up on Million Hearts® initiative and continue to monitor progress.

Reminders

- MCP to ensure representation and participation at Global Medi-Cal DUR Board meetings, either in-person or via webinar. Refer to the Global Medi-Cal DUR Board bylaws for the attendance requirements for Global Medi-Cal DUR Board members.
- MCP to have a process for distribution of provider education programs and materials developed by Global Medi-Cal DUR Board to their providers via established mechanisms.

Auto-Refill

- DHCS is considering a requirement that pharmacies auto-refill only upon a patient's consent or request.
- The Board held discussions at the May 22, 2018 and September 18, 2018 meetings
- The Board motioned to hold further discussions at the November 27, 2018 meeting
- What is the Board's recommendation?



Auto-Refill (cont.)

- Pharmacies may auto-refill only upon a patient's consent or request.
- Pharmacies may perform patient outreach to initiate refills in attempts to improve medication adherence and clinical outcomes.
- Pharmacies do not offer financial incentives to influence beneficiary decisions about when or where to fill prescriptions paid by a federally funded program.

Reference:

[CMS Pharmacy Self-Auditing: Control Practices to Improve Medicaid Program Integrity and Quality Patient Care – Booklet 4: Billing Practices](#), page 6-8.



Global Medi-Cal DUR Board Priorities

Andrew Wong, M.D.
Chair, Global Medi-Cal DUR Board



Global Medi-Cal DUR Board Priorities

- Not enough time for discussion of priorities at last Board meeting
- The four topic clusters had almost equal votes
 - Two topic clusters received seven votes
 - Two topic clusters received six votes



Questions to Consider for DUR Board Priorities

- Is there a specific group or groups of specialty pharmacy drugs that should be included?
- Are there existing measures or standards to use on quality of care? Cost effectiveness?
- What are the DUR opportunities?
- What high impact educational interventions should we choose?



Topic Clusters

- Optimizing Drug Prescribing and Dispensing
- Optimizing Pain Management and Opioids
- Optimizing Chronic Disease Management
- Optimizing Biologics, Specialty Drugs, and Cost-effective Care



Optimizing Drug Prescribing and Dispensing

1. Appropriate Use of Medication in High Utilizers and Super Utilizers
2. Formulary Review: Prior Authorization Process Improvement
3. Medication Use Optimization: Reduce Polypharmacy and Eliminate Unnecessary Drugs
4. Strategies to Prevent Filling Prescriptions Already Cancelled
5. Fostering Closer Collaboration between Medical and Pharmacy Services for Optimal Care



Optimizing Pain Management and Opioids

1. Opioids and Benzodiazepine Combination Use
2. Alternative Medicine (Pain Management) as Covered Benefits: Acupuncture
3. Pain Management Guidelines



Optimizing Chronic Disease Management

1. Diabetes Management
2. Hypertension Management
3. Optimal Drug Use: Population Health and Chronic Disease Management
4. Optimal Drug Use: Population Health and Longitudinal Studies
5. Whole-Person Care: Social Determinants
6. Quality Integration in Health Plan



Optimizing Biologics, Specialty Drugs, and Cost-effective Care

1. Specialty Drugs and Biosimilar Drugs
2. Specialty Pharmacy: Cost Effectiveness and Quality of Care
3. Biologics in Immunotherapy: (e.g., CAR T-Cell Therapy)



Proposal

- Integrate the priorities in the proposed DUR Vital Direction Framework

Reference:

Dzau, VJ et al. Vital Directions for Health and Health Care: Priorities From a National Academy of Medicine Initiative. JAMA online March 21, 2017.



**PROPOSAL:
VITAL DIRECTIONS FOR THE
GLOBAL MEDI-CAL DRUG USE REVIEW (DUR) PROGRAM**

Federal Fiscal Year (FFY) 2019

Background

Through the [Vital Directions for Health and Health Care Initiative](#), the National Academy of Medicine (NAM; formerly the Institute of Medicine) called on more than 150 leading researchers, scientists, and policy makers from across the United States to provide expert guidance on 19 priority focus areas for U.S. health policy. In conjunction with the discussion papers, the Journal of the American Medical Association (JAMA) published 2 editorials and 19 Viewpoints that coincide with each discussion paper.

In March 2017, JAMA published the article, "[Vital Directions for Health and Health Care](#)." In this article, experts concluded our nation's enormous challenge in health and health care is beyond providing affordable healthcare and must now address the fundamental issues of structural inefficiencies, unprecedented costs, and a fragmented care delivery system. To this end, the group offered a framework of priorities and essential infrastructure needs. The article called for leaders in health systems across the country to review these priorities and to build the infrastructure needed to achieve the goal of better health at lower cost.

Following the framework outlined by NAM's initiative, the following is a draft proposal for Vital Directions for the Global Medi-Cal Drug Use Review (DUR) Board.

Mission

The mission of the Global Medi-Cal DUR Board is to facilitate the appropriate and cost effective delivery of health of the Medi-Cal beneficiaries.

Vision

The Global Medi-Cal DUR Board's vision is to work collaboratively, including FFS and managed care health plans, to enable and to empower providers (physicians, pharmacists) and beneficiaries to perform optimally, in drug prescribing and dispensing, with the goal of shifting and optimizing utilization towards a safe, accessible, cost effective (high value) care.

Core Goals

1. Better health and well being
 - a. Identify optimal drug use practice through prospective and retrospective drug use review
 - b. In designing educational interventions, consider using multiple media and approaches to effect both providers and beneficiaries change (care instructions not poorly written and can be well understood)
2. High-value health care
 - a. Acknowledge current health care cost is unsustainable
 - b. Reduce cost by addressing waste and unnecessary duplicate care (excessive quantity supply, eliminate duplicate therapy)
 - c. Reduce cost by drug problems avoidance (drug interactions, contraindications, harmful excessive quantity supply)
3. Strong science and technology
 - a. Use quality measure standards that are rigorous and evidence-based
 - b. Use available resources in data, technology, expertise and support
 - c. Include pharmacoeconomics in the analytical toolbox
4. Create organizational synergy and be a part of the coalition with other quality initiatives from DHCS, CDPH and other entities. Examples include Statewide Opioid Workgroup and Million Hearts Initiatives.

Action Priorities

1. Optimizing drug prescribing and dispensing
2. Optimizing biologics, specialty drugs and cost-effective care
3. Optimizing pain management and opioids use
4. Optimizing chronic disease management

Within each of these four action priorities, consider:

1. Creating or adopting a set of core metrics for continuous tracking and trending over time.
2. Selecting educational interventions that align with top priorities identified by the DUR board.
3. Publishing retrospective DUR criteria that align with up-to-date national guidelines. In situations where multiple guidelines exist or overlap, provide guidance.
4. Using a systematic approach to assess data collection methodology for optimal data use.
5. Promoting and spreading the use of Academic Detailing to accelerate improvement in prescribing (physicians) and providing pharmaceutical services (pharmacies, pharmacists).
6. Considering other prospective DUR interventions besides alerts - such as applying levers using quantity limits, pharmacist intervention (corresponding responsibilities), and prior authorization.
7. Adopting best practices from other states. This could include a thorough and comprehensive analysis of the Centers for Medicare and Medicaid Services (CMS) annual DUR state comparison report, published annually.

Essential Infrastructure Needs

1. Measure what matters most
 - a. Perform an annual review of the Medicaid Child Core Set, Medicaid Adult Core Set, Managed Care Performance Measurements and Indicators
 - b. Make available self-study courses, training modules and certificate programs on performance measurement standards and practices
2. Clinical Practice Guidelines
 - a. Use up-to-date guidelines to develop retrospective DUR criteria
 - b. In situation where multiple guidelines exist or overlap, be a “thought leader” and provide guidance
 - c. Track and prioritize guidelines and monitor updates release dates
 - d. Disseminate on a timely manner information on guidelines release and updates
3. Academic Detailing
 - a. Support training of academic detailers
 - b. Move from pilot to implementation
 - c. Empower front line providers (prescribers and pharmacists)

Summary

The NAM initiative calls for leaders in health systems across the country to review these priorities and to build the infrastructure needed to achieve the goal of better health at lower cost.

November 2018 marks the end of the first year of the board transitioning from a Medi-Cal Fee-for-Service DUR board to the Global Medi-Cal DUR Board, which includes Medi-Cal managed care health plans. This transition year has been a tremendous mutual learning experience for all. Moving forward, this framework could be useful to guide the Board’s work. Identifying priority actions and incorporating these actions into the board’s goals is just the first step.

2019 Vice Chair Election Eligible Board Members

- Timothy E. Albertson, MD, MPH, PhD
- Michael Blatt, PharmD
- Chris Chan, PharmD
- Lakshmi Dhanvanthari, MD
- José Dryjanski, MD
- Stan Leung, PharmD
- Johanna Liu, PharmD, MBA, FCPHA
- Janeen McBride, PharmD
- Robert Mowers, PharmD
- Yana Paulson, PharmD
- Marilyn Stebbins, PharmD
- Vic Walker, RPh
- Andrew L. Wong, MD
- Iris Young, PharmD, CPHQ
- Ramiro Zuniga, MD, MBA, AAFP



MEDI-CAL DRUG USE REVIEW BOARD

BYLAWS

Sections:

1. Mission Statement
2. Authority
3. Membership
4. Term of Office
5. Officers
6. Meetings
7. Program Description
8. Annual Report
9. DUR Board Documents
10. Public Participation
11. Conflict of Interest Statement
12. Revision and Compliance

1. Mission Statement

The mission of the Medi-Cal DUR Board is to facilitate the appropriate and cost effective delivery of health of the Medi-Cal beneficiaries.

2. Authority

The Drug Use Review (DUR) board is authorized pursuant to Section 1927(g)(3) [42 U.S.C. 1396r-8] of the Social Security Act, also known as section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) released final rulemaking CMS-2390-F, which requires the Managed Care Plans (MCPs) to operate a DUR program that complies with the requirements of Section 1927(g) of the Social Security Act (SSA) and Title 42, CFR part 456, subpart K.¹

¹ Title 42, CFR, Section 438.3(s)(4)

The complexities of the federal DUR requirements necessitate that MCPs utilize the established Medi-Cal State DUR Board (DUR Board) and educational components of the Medi-Cal DUR program. However, MCPs will maintain their current proprietary claims processing procedures and protocols and the MCPs will individually administer the systematic components related to the prospective and retrospective DUR processes. As is the case with the Fee-For-Service (FFS) program, MCPs are not required to implement all DUR Board recommended actions, nor are they required to mirror the Medi-Cal DUR activities. Effective July 1, 2017, in collaboration with DHCS' FFS program for covered outpatient drugs, MCPs shall participate in a global Medi-Cal DUR program.

The Board shall serve in an advisory capacity to the Department of Health Care Services (Department), the California state Medicaid agency (Medi-Cal) to assure that its DUR program is operational and fulfills the requirement of the Act.

3. Membership

The Board shall consist of at least one-third but not more than 51 percent physician members and at least one-third pharmacist members. The Director of the Department shall determine the size and composition of the Board, including the types of members considered appropriate to contribute their expertise to the DUR program. The size and composition of the board may be expanded to include representation from managed care health plans.

Board members must be actively practicing and licensed in California. Board members shall be health care professionals who have recognized knowledge and expertise in one or more of the following areas: the clinically appropriate prescribing of outpatient drugs; the clinically appropriate dispensing of outpatient drugs; drug use review, evaluation and intervention; and medical quality assurance.

4. Term of Office

The term of office shall be at the pleasure of the Department's Director. Appointment to the DUR Board is the sole responsibility of the Director upon recommendation from the

Chief of Medi-Cal Pharmacy Policy. The length of appointment and the conditions of replacement shall take into account the ongoing nature of the Board's deliberations and shall provide for at least three overlapping appointments. Rotation off the Board will be activated based on the discretion of the Department, and related to the availability of approved Board members for replacement. Should any Board member be unable to fulfill his/her appointment term, that member should provide written notice to the Chair prior to resignation. While the board meetings may be accessed by the public via teleconference, board members shall attend in person to count for attendance and to vote. If a Board member is unable to attend three or more consecutive meetings, these absences shall be considered a voluntary vacancy on the Board and the Chair shall request a resignation.

5. Officers

Officers shall consist of a Chair and Vice-Chair/Chair-Elect, who shall be elected every year during the third quarter meeting of the Board. The Chair shall preside over Board meetings. The Vice-Chair shall preside over Board meetings in the Chair's absence. The Vice-Chair shall serve as the Chair-elect and succeed the Chair upon completion of his/her term. Prior to serving as Chair or Vice Chair, Officers should have served on the Board at least one year and may be reelected at the Board's discretion. The term of the chair is one year. The term of the vice-chair is one year.

6. Meetings

Meetings shall be held at least quarterly at a time and place determined by the Department. All meetings will operate under the restrictions of the Bagley Keene Open Meetings Act, set forth in Government Code sections 11120-11132. The Board shall meet in open public session, but can meet in executive session to review confidential information. Information reviewed by the Board that identifies an individual Medi-Cal recipient or provider shall be considered confidential and shall not be disclosed. Robert's Rules of Order shall be used to conduct meetings. A simple majority of members shall constitute a quorum and a simple majority is all that's needed for a motion to pass. If a specific issue requires immediate action and a Board meeting will not occur in a timely

fashion, Board members may be contacted and asked to vote electronically. Upon approval of an item under consideration, it may be acted on immediately.

Meeting minutes will be taken as a basic form of proof that a meeting took place as well as a historical documentation of where, when, and why the meeting was held. Minutes should contain location, date, time, list of attendees and key points of discussion. Meeting minutes are public documents and are available to the public upon request.

To aid the proper capture of the meeting minutes, the meeting may be recorded. The recording is a public record and is available for 30 days to the public upon request. Any person attending a board meeting may also record the proceeding via audio, video, or still camera unless such actions constitute or would constitute a persistent disruption of the proceedings (Government Cod § 11124.1).

7. Program Description

The program shall focus on medication therapies with the broad goals of improving patient outcomes, increasing the quality of prescribing practices, reducing healthcare costs, and improving beneficiary, prescriber, and pharmacist satisfaction. Towards these goals, the program shall implement strategies that identify and reduce adverse events, fraud, misuse, overutilization, underutilization, and inappropriate/ineffective care associated with specific drugs or groups of drugs. Strategies for improving prescribing may include education, data reports, audits, alerts, incentives, decision-making tools, and outreach aimed at beneficiaries, prescribers, and pharmacists.

There are three key functions of the DUR program:

- A. Prospective DUR
- B. Retrospective DUR
- C. Medication interventions designed to educate health care providers, pharmacists and beneficiaries

For both Prospective DUR and Retrospective DUR, the program shall assess data on drug use against predetermined standards, consistent with the following:

(i) compendia which shall consist of the following:

(I) American Hospital Formulary Service Drug Information;

(II) United States Pharmacopeia-Drug Information (or its successor publications); and

(III) the DRUGDEX Information System; and

(ii) the peer-reviewed medical literature.

(iii) Evidence-based practice guidelines as developed by the Medi-Cal Drug Advisory Committee (MCDAC) and disease-specific health improvement programs developed by the State.

A. Prospective DUR

Prospective DUR is performed electronically at the time a drug is dispensed to a patient. This review is designed to identify potential problems such as drug-drug interactions, therapeutic duplication, inappropriate dosage, or duration of therapy. When a pharmacist is alerted to a potential problem, he or she is expected to use professional judgment to determine an appropriate intervention. Retrospective DUR examines drug use after the drug has been dispensed. The principal aim of retrospective DUR is to discern patterns of inappropriate or suboptimal drug use and engage in interventions to providers to prevent future unfavorable or undesirable outcomes.

The DUR Board is responsible to the Department for the following specific Prospective DUR activities:

1. The DUR Board shall, on an ongoing basis, serve in an advisory capacity to assess prospective alert data against explicit predetermined standards (currently using First Data Bank as the source for these standards) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease

contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, recommend remedial strategies, in order to improve the quality of care and to conserve program funds or personal expenditures.

2. Noting that standards of care and practices change with time, the DUR Board shall serve in an advisory capacity in the development and implementation of an evidence-based methodology for determining standards to identify, classify, target, and act upon those drug interactions that pose the greatest risk for drug-induced illness.
3. After determining what alerts are important, the Board shall serve in an advisory capacity to determine electronic messaging, focusing on the following principles:
 - i. Clarity: the “what”
 - ii. Understandability: the “why”
 - iii. Actionable
 - iv. Interoperability
 - v. Standardized
 - vi. Non-redundant

B. Retrospective DUR

1. Retrospective DUR is a two-part system: The first component is the ongoing periodic examination of claims data and other records to identify patterns of Medi-Cal fraud, abuse, gross overuse, or inappropriate and unnecessary care among physicians, pharmacists and Medi-Cal recipients associated with specific drugs or groups of drugs. The purpose of this component is to reduce the frequency of misuse and overuse of Medi-Cal drug benefits.
2. The second component of retrospective DUR is an ongoing periodic examination of claims data and other records to assess the clinical appropriateness of prescribing and dispensing of select Medi-Cal covered drugs. This includes monitoring for therapeutic appropriateness, overutilization and underutilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions,

incorrect drug dosage or duration of drug treatment, clinical abuse/misuse and variations from best practice guidelines.

The DUR Board is responsible to the Department for identifying common drug therapy problems to educate providers and improve prescribing and dispensing practices. The Board also shall serve in an advisory capacity to recommend types of intensified recipient- or provider-specific interventions that shall most effectively improve the quality of drug therapy.

- C. Medication interventions designed to educate health care providers and pharmacists, targeted toward therapy problems or individuals identified in the course of retrospective drug use reviews. Intervention programs shall include, in appropriate instances, at least:
1. Information dissemination sufficient to ensure the ready availability to physicians and pharmacists in the State of information concerning its duties, powers, and basis for its standards;
 2. Written, oral, or electronic reminders containing patient-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of patient-related information;
 3. Use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices, and follow-up face-to-face discussions; and
 4. Intensified review or monitoring of selected prescribers or dispensers.

The Board shall re-evaluate interventions after an appropriate period of time to determine if the intervention improved the quality of drug therapy, to evaluate the success of the interventions and make modifications as necessary.

Additional functions of the DUR board to include:

D. The DUR Board will provide input to the Medi-Cal Drug Advisory Committee regarding the Medi-Cal formulary based on the analysis of the retrospective and prospective DUR programs and patient outcomes and when fraud, overuse have been identified. Similarly, the Board may provide input to the managed care Pharmacy & Therapeutic Committee or equivalent, based on the analysis of the retrospective DUR programs and outcomes that overlaps both FFS and managed care beneficiaries.

E. The Board periodically evaluates and recommends modification, addition or elimination of prospective and retrospective DUR criteria and standards.

F. The Board periodically evaluates and recommends modification, addition or elimination of existing prospective and retrospective DUR reports.

8. Annual Report

The DUR board shall prepare a report in accordance to the questionnaire and template provided by the Centers for Medicaid and Medicare Services (CMS) on an annual basis which may include a description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of such program. The board shall make every effort to review and approve the annual report on a timely basis, to allow sufficient time for the Department to submit the annual report within the timeline specified by CMS.

9. DUR Board Documents

All meeting minutes and other official records of the DUR board shall be kept on file at the Department and/or fiscal intermediary offices for a period of three years and shall be open to public inspection.

10. Public Participation

The public may attend all Board meetings, with the exception of Executive Sessions called to discuss confidential information. The Board may make and enforce reasonable rules regarding the conduct of persons attending its meetings. Opportunities shall be provided for individuals or representatives of groups to make comments to the Board. Requests to appear before the Board shall be made in writing and shall include the subject matter and name and affiliation of the speaker. Presentations are limited to five minutes unless the Board grants an extension.

11. Conflict of Interest Statement

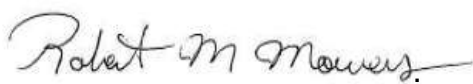
A conflict of interest shall exist for a board member when a matter under consideration by the Board directly affects a personal, professional or monetary interest of a Board member. A member shall disclose any conflict of interest preceding consideration of substantive matters or at the point when it becomes apparent to the member that a conflict exists. Minutes of the meeting shall reflect the conflict and abstention from voting for that member.

12. Revision and Compliance

In the event specific topics require detailed elaboration, the board will create a supplementary addendum to the bylaws so as to include this information. The bylaws shall be reviewed as necessary to assure compliance with Section 1927(g)(3) [42 U.S.C. 1396r-8] of the Social Security Act, also known as section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). Revisions shall be made as necessary and after approval by the Department Director. The bylaws shall be signed and dated to indicate the time of last review.

The bylaws shall go into effect on the 19th day of the month September, in year 2017.

Approved:



Chair, Medi-Cal DUR Board



Medi-Cal FFS Pharmacy Reimbursement Methodology Changes for Covered Outpatient Drugs

Trudi Balestreri, MBA, PMP
Pharmacy Policy Branch
11-27-18



Topics

- Background
- Drug Ingredient Cost Reimbursement
- Professional Dispensing Fee Reimbursement
- Resources
- Questions





Background

- In February 2016, the Centers for Medicare and Medicaid Services (CMS) released the Covered Outpatient Drug Rule (COD), requiring State Medicaid Agencies to submit a State Plan Amendment to implement a COD reimbursement methodology consistent with the final rule
- Effective date of the new methodology was to be no later than April 1, 2017
- Required states to base their reimbursement for drug ingredient costs on actual acquisition cost (AAC). Most states had been using AWP, with CA at AWP - 17%.
- Required states to revisit their professional dispensing fee reimbursement.



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Background (cont.)

- States were given the option of leveraging national or state surveys as their basis for AAC, or another pricing benchmark, as long as the state could demonstrate its relationship to AAC.
- DHCS contracted with Mercer to conduct two CA specific surveys to inform the development of CA's reimbursement methodology:
 - Actual Acquisition Cost (AAC) Survey
 - Professional Dispensing Fee (PDF) Survey
- DHCS conducted five Pharmacy Stakeholder Outreach sessions between June 2016 and January 2017 inviting providers to participate in the survey process



Medi-Cal DUR Board Meeting 11-27-18



Drug Ingredient Cost Reimbursement

Previous:

- Lowest of AWP-17%, Federal Upper Limit (FUL), Maximum Allowable Ingredient Cost (MAIC)

New:

- CMS's National Average Drug Acquisition Cost (NADAC) replaces AWP-17% in the "lowest of" formula. When a NADAC is not available, Wholesale Acquisition Cost (WAC) +0% will be used as the backup.

* Total reimbursement will continue to be based on the "lowest of" the drug ingredient cost, plus a professional dispensing fee, or Usual and customary charges.



Medi-Cal DUR Board Meeting 11-27-18



Professional Dispensing Fee Reimbursement

Previous:

- \$7.25 retail community pharmacy
- \$8.00 pharmacies in a long term care setting

New:

- Two-tiered, based on total annual (Medi-Cal and non Medi-Cal) claim volume. Requires annual provider attestation:
 - Less than 90,000 prescriptions dispensed = \$13.20
 - 90,000 or more prescriptions dispensed = \$10.05



Medi-Cal DUR Board Meeting 11-27-18



Resources

The Pharmacy Reimbursement Project Website:

[Project website](#)

CMS Methodology for Calculating the NADAC:

[Methodology](#)

CMS NADAC Help Desk Form:

[Help Desk Form](#)



Medi-Cal DUR Board Meeting 11-27-18



Questions?

Trudi.Balestreri@dhcs.ca.gov



Medi-Cal DUR Board Meeting 11-27-18



UCSF School of Pharmacy

Retrospective DUR Updates: Q3 2018

Shal Lynch, PharmD, CGP
Health Sciences Associate Clinical Professor
Department of Clinical Pharmacy
School of Pharmacy

Retrospective DUR Updates – Q3 2018



Topic for Discussion

- Review of Retrospective DUR Criteria: New Additions to the Medi-Cal FFS Contract Drugs List (FFY 2017)
- Review of Retrospective DUR Criteria: Utilization of Hepatitis C Virus (HCV) Drugs
- FFS Quarterly Report: 3Q2018
- Review of FFS Physician Administered Drugs (PADs): 2Q2018
- Discussion of Current/Proposed Data Reports

FFS CDL Adds (FFY 2017) - Background



- Each month there are usually modifications made to the Medi-Cal Fee-for-Service Contract Drugs List (CDL), including the addition of new drugs

FFS CDL Adds (FFY 2017) - Objective



Objective

- To evaluate utilization patterns for drugs added to the CDL, in order to identify potential drug problems and/or areas where additional review is warranted

This evaluation is completed on an annual basis, with results presented each year at the November DUR Board meeting

FFS CDL Adds (FFY 2017) - Methods

Methods

- During the Federal Fiscal Year 2017 (between 10/1/16 and 9/30/17), there were a total of 16 new prescription medications added to the CDL
- Utilization data were reviewed for each drug between 10/1/15 and 08/31/18
 - Allows at least 11 months of review before and after the drug was added to the CDL

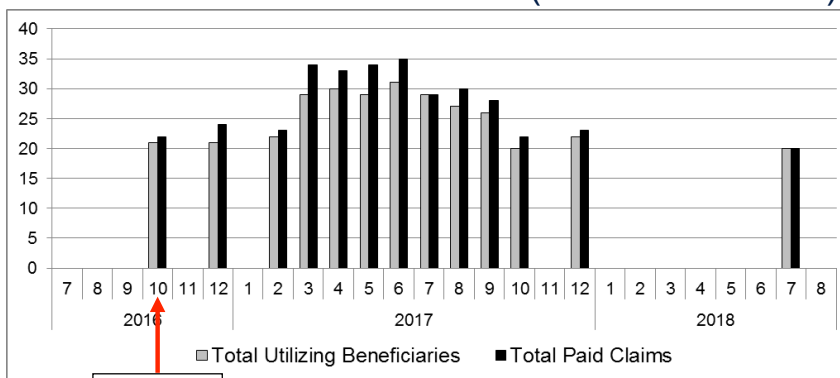
FFS CDL Adds (FFY 2017) - Drugs

Date Added	Drug	Drug Therapeutic Category
10/1/2016	SOFOSBUVIR/VELPATASVIR	ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB
12/1/2016	CLOPIDOGREL BISULFATE	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS
1/1/2017	OLARATUMAB*	PLATELET AGGREGATION INHIBITORS
3/15/2017	RIBOCICLIB SUCCINATE*	ANTI-PROGRAMMED CELL DEATH-LIGAND 1 (PD-L1) MAB
3/27/2017	AVELUMAB*	BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED
4/1/2017	TEMSIROLIMUS*	ANTINEOPLASTIC- CD22 ANTIBODY-CYTOTOXIC ANTIBIOTIC
4/1/2017	TENOFOVIR ALAFENAMIDE FUMARATE	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS
4/19/2017	NIRAPARIB TOSYLATE*	OPIOID ANALGESICS
5/1/2017	DURVALUMAB*	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS
5/1/2017	MIDOSTAURIN*	ANTINEOPLASTIC, PDGFR-ALPHA BLOCKER MC ANTIBODY
5/12/2017	BRIGATINIB*	ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS
5/18/2017	RIBOCICLIB SUCCINATE/LETROZOLE*	ANTINEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT
7/3/2017	RITUXIMAB/HYALURONIDASE, HUMAN*	ANTI-CD20 (B LYMPHOCYTE) MONOCLONAL ANTIBODY
8/1/2017	MORPHINE SULFATE/NALTREXONE*	HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.
8/17/2017	INOTUZUMAB OZOGAMICIN*	ANTINEOPLASTIC - MTOR KINASE INHIBITORS
9/1/2017	GLYCOPYRROLATE/ FORMOTEROL FUMARATE*	HEPATITIS B TREATMENT AGENTS

**Drugs without graphical representations due to low utilization (< 20 utilizing beneficiaries each month)*

FFS CDL Adds (FFY 2017) – Figure 1

SOFOSBUVIR/VELPATASVIR (added 10/1/2016)

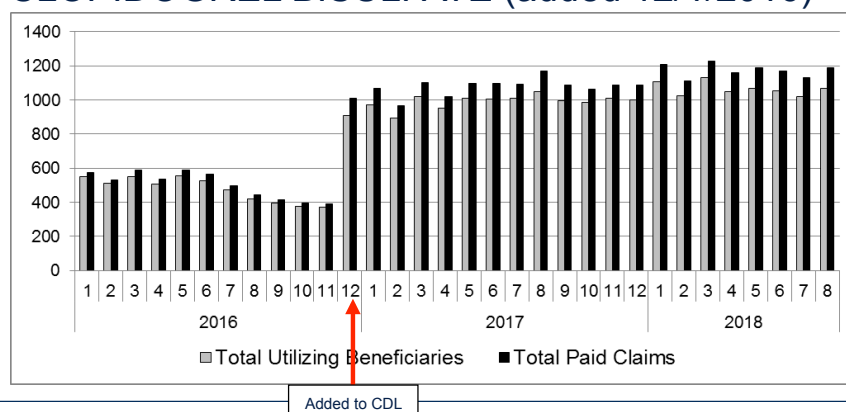


7 Retrospective DUR Update – 2018Q3 (6/1/18 – 9/30/18)

UCSF

FFS CDL Adds (FFY 2017) – Figure 2

CLOPIDOGREL BISULFATE (added 12/1/2016)

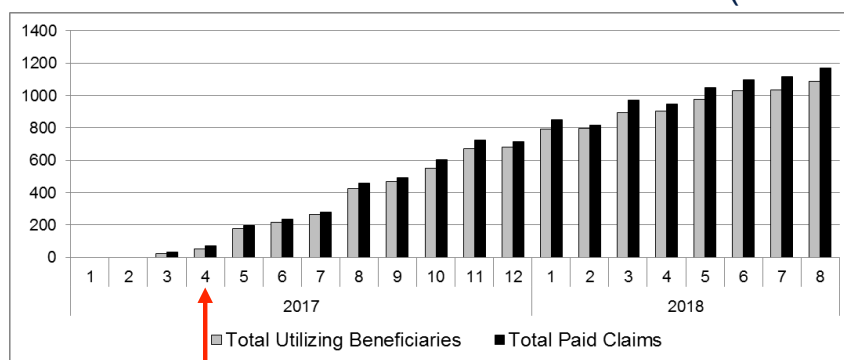


8 Retrospective DUR Update – 2018Q3 (6/1/18 – 9/30/18)

UCSF

FFS CDL Adds (FFY 2017) – Figure 3

TENOFOVIR ALAFENAMIDE FUMARATE (added 4/1/2017)



Months shown without data means there were < 20 utilizing beneficiaries that month

Restricted to use in the treatment of chronic Hepatitis B virus infection only.

Added to CDL

FFS CDL Adds (FFY 2017) - Action

Suggested Board action:

- Review and discuss the utilization data to determine if there is a need for further evaluation of any of the drugs added to the Medi-Cal Fee-for-Service Contract Drugs List during the 2017 Federal Fiscal Year



Board recommendations?



HCV Drugs - Background

- More than 3 million people in the United States are living with hepatitis C virus (HCV) infection
 - ~17,000 new HCV cases each year (estimate only half are reported)
 - 75%–85% of newly infected persons develop chronic HCV infection
- Without treatment, chronic HCV infection can lead to serious liver problems
- HCV-related deaths in the US continue to increase

HCV Drugs - Background (cont.)



- Treatment options for HCV infection have been evolving continuously since the introduction of HCV protease inhibitor therapies in 2011
 - Within Medi-Cal fee-for-service, all drugs except ribavirin are covered with an approved *Treatment Authorization Request* (TAR)
 - In July 2018, DHCS revised its [Treatment Policy for the Management of Chronic Hepatitis C](#)
 - In August 2018, MCPs received [APL #18-013 Hepatitis C Virus Treatment Policy Update](#)

HCV Drugs - Objective



- To evaluate the utilization of drugs used to treat HCV infection, including an assessment of potential HCV reinfection and retreatment in the Medi-Cal fee-for-service population.

In November 2016 the DUR Board recommended this evaluation be conducted on an annual basis. Previous reports covered data from FFY 2016 and FFY 2017.

HCV Drugs - Methods

- Paid claims for all HCV medications with dates of service between September 1, 2017 and August 31, 2018 were reviewed for Medi-Cal fee-for-service beneficiaries.
- During this measurement year, a total of 496 beneficiaries were identified as having a paid claim for an HCV medication, for a total number of 1,085 paid claims.
 - A total of 310 beneficiaries were continuously-eligible in the Medi-Cal fee-for-service program throughout the measurement year, with a total number of 736 paid claims for an HCV medication

HCV Drugs – Utilization Data FFY 2018

Continuously-eligible Medi-Cal fee-for-service beneficiaries ≥ 18 years of age with chronic hepatitis C infection (dates of service between September 1, 2017 and August 31, 2018).

Drug	Total Utilizing Beneficiaries (n=310)*	Total Paid Claims
daclatasvir	< 20	< 20
elbasvir/grazoprevir	42	<18
glecaprevir/pibrentasvir	182	103
ledipasvir/sofosbuvir	247	95
peginterferon alfa-2a	22	< 20
peginterferon alfa-2b	< 20	< 20
ribavirin	58	26
sofosbuvir	< 20	< 20
sofosbuvir/velpatasvir	140	65
sofosbuvir/velpatasvir/voxilaprevir	22	< 20

*Some beneficiaries may be on more than one medication.

HCV Drugs – Discussion



- In comparison with FFY 2017 utilization data:
 - Two drugs had no paid claims in FFY 2018:
 - ombitasvir/paritaprevir/ritonavir/dasabuvir
 - simeprevir
 - One new drug had utilization:
 - glecaprevir/pibrentasvir (added to FFS CDL on January 1, 2018)

HCV Drugs – Discussion (cont.)



- Slight uptick in utilizing beneficiaries since the policy change
 - Average of 29.5 new starts in July/August of 2018 vs. average of 22.4 new starts in the preceding 10 ten months
- All beneficiaries had at least one HCV-RNA level, HCV genotype test, and comprehensive metabolic panel
- Total continuously-eligible utilizing beneficiaries decreasing over time (459 total in FFY 2017 and 489 total in FFY 2016)
- Limitations for additional analysis include small study population, lack of clinical data

HCV Drugs - Action



Suggested Board actions:

- Discuss whether a follow-up evaluation further examining the impact of the new DHCS treatment policy would be useful a year after implementation
 - Could include MCP data in aggregate with FFS data, or include as comparison group
- Given that pharmacy and medical claims data continue to show use of these drugs follow clinical guidelines, discuss the appropriate frequency for reviewing HCV drug utilization

Board recommendations?



FFS Quarterly Report: 3Q2018



- Each year in the Q3 report we provide the annual utilization summary of drugs by sourcing status that will be included in the annual report (**Table 7.1**)
- For reference, **Table 7.2** presents the top 10 drugs in each source code category, by total utilizing beneficiaries
- Source status determined through National Drug Code (NDC)
- Data are consistent with prior years

Board recommendations?



Review of FFS PADs: 2Q2018



- Next PADs report (presented at the February meeting) will be the last one missing prior-year data for vaccine administration
 - Tables 2 and 3 should normalize
- Vaccines dropped overall from 1Q2018 to 2Q2018, except for TDAP in children greater than 7 years of age
 - Consistent annual overall vaccine decrease seen in Q2 correlates with decreased utilization of seasonal vaccines
 - Consistent annual increase in TDAP use in Q2 and Q3 seems to align with immunization requirements for California schools

Board recommendations?



DUR Data Reports: Background



New Opportunities:

- Expansion to Global Medi-Cal DUR Board
- Access to new database

New Challenges:

- Timing of data upload varies by program and claim type
- Existing standard data report structure/deliverable schedule may not be meeting everyone's needs
 - Includes all templated reports, not ad hoc analyses

DUR Data Reports: Proposed Changes



- Develop two new all-inclusive (FFS and MCP) Medi-Cal reports
 - Pharmacy utilization (annual)
 - Physician-administered drug (PAD) utilization (annual)
- Change FFS annual pharmacy utilization report
 - Expand on what is required for the annual report to CMS and add in comparison data (to prior year)
- Change current FFS PAD report from quarterly to annual

Current Data Report Timeframe

Q1 Meeting (Feb):

- Quarterly Fee-for-Service Pharmacy Utilization*
- Quarterly Fee-for-Service PAD Utilization
- Annual Fee-for-Service Pharmacy Utilization (FFY only, no comparison)*

Q2 Meeting (May):

- Quarterly Fee-for-Service Pharmacy Utilization*
- Quarterly Fee-for-Service PAD Utilization

Current Data Reports

Q3 Meeting (Sept):

- Quarterly Fee-for-Service Pharmacy Utilization*
- Quarterly Fee-for-Service PAD Utilization

Q4 Meeting (Nov):

- Quarterly Fee-for-Service Pharmacy Utilization*
- Quarterly Fee-for-Service PAD Utilization

***Current deliverable**

Proposed Data Report Timeframe

Q1 Meeting (Feb):

- Quarterly Fee-for-Service Pharmacy Utilization
- Annual Fee-for-Service Pharmacy Utilization (FFY compared with prior FFY)

Q2 Meeting (May):

- Quarterly Fee-for-Service Pharmacy Utilization
- Annual Medi-Cal Pharmacy Utilization (FFY compared with prior FFY)

Proposed Data Reports

Q3 Meeting (Sept):

- Quarterly Fee-for-Service Pharmacy Utilization
- Annual Fee-for-Service PAD Utilization (FFY compared with prior FFY)

Q4 Meeting (Nov):

- Quarterly Fee-for-Service Pharmacy Utilization
- Annual Medi-Cal PAD Utilization (FFY compared with prior FFY)

Can begin this reporting timeline at the next meeting (February 2019)

Board recommendations?

Future Topics: Retrospective Reviews

- Annual review of drugs added to the Medi-Cal List of Contract Drugs (ongoing, presented each November)
- HCV medications (ongoing, presented each November)
- Pharmacist furnishing of hormonal contraceptives
- Assessment of opioid use and mortality (stratified by gender)
- Biennial Report (presenting in February and May, 2019)
- Topics from today's meeting: DUR Board Priorities

Future Topics: Adult Core Set Measures



- 2018 Adult Core Set Measures:
 - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
 - Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
 - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
 - Concurrent Use of Opioids and Benzodiazepines (COB-AD)
 - Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)

Future Topics: Child Core Set Measures



- 2018 Child Core Set Measures:
 - Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
 - Asthma Medication Ratio: Ages 5–18 (AMR-CH)
 - Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)



Board recommendations?

QUARTERLY SUMMARY
MEDI-CAL FEE-FOR-SERVICE PROGRAM DRUG USE REVIEW
REPORT PERIOD: 3rd QUARTER 2018 (JULY – SEPTEMBER 2018)

Executive Summary

The DUR quarterly report provides information on both prospective and retrospective drug utilization for all claims processed by the Medi-Cal Fee-for-Service (FFS) program, including the carved-out drug claims for the Medi-Cal Managed Care Plans (MCPs). For this quarterly report, the prospective and retrospective data cover the third quarter of 2018 (2018 Q3). All tables can be found in **Appendix A** and definitions of selected terms can be found in **Appendix B**.

Prospective DUR

As shown in Table 1.1, in comparison to the prior quarter (2018 Q2), in 2018 Q3 overall drug claims decreased by 3% and total DUR alerts also decreased by 3%. In comparison to the prior-year quarter (2017 Q3), overall drug claims decreased by 1% while total DUR alerts increased by 12%. The increase in total DUR alerts is primarily due to an update to the therapeutic duplication (TD) alert, which was effective in 2017 Q4.

A comparison between 2018 Q3 and 2018 Q2 showed very little change among the summary of alert transactions by therapeutic problem (**Table 1.2**) and among the top 10 drugs for each of the 12 prospective DUR alerts (**Tables 2.1-2.12**).

Retrospective DUR

Due to a slight lag in processing time, the aggregate tables contain complete retrospective claims data, while the stratified tables are not yet complete for 2018 Q3. For this report, the stratified tables represent 94.6% of total paid claims represented in the aggregated tables.

In 2018 Q3, approximately 14% of eligible Medi-Cal FFS enrollees had a paid claim through the Medi-Cal fee-for-service program, compared with only 2% of Medi-Cal MCP enrollees (**Table 3.2** and **Table 3.3**). Among all Medi-Cal beneficiaries with a paid claim through the Medi-Cal fee-for-service program in 2018 Q3, 56% were FFS enrollees and 35% were MCP enrollees (numbers add up to greater than 100% due to < 1% of beneficiaries being enrolled in both programs during 2018 Q3).

Of note, **Table 5.2** and **Table 6.2** show the top 20 drug therapeutic drug categories and top 20 drugs of Medi-Cal FFS program enrollees, while **Table 5.3** and **Table 6.3** show the top 20 drug therapeutic drug categories and top 20 drugs by beneficiaries enrolled in Medi-Cal MCPs. These tables give a more in-depth look at the impact of carved-out drugs on tables showing overall pharmacy utilization in the Medi-Cal fee-for-service program (**Table 5.1** and **Table 6.1**).

Finally, each year in the Q3 report we provide the annual utilization summary of drugs by sourcing status that will be included in the annual report (**Table 7.1**). For reference, **Table 7.2** presents the top 10 drugs in each source code category, by total utilizing beneficiaries. Source status is determined through National Drug Code (NDC). Across all three categories the top NDC codes by total utilizing beneficiaries in the Federal fiscal year 2018 (FFY 2018) were almost identical to the previous year (FFY 2017).

Appendix A: Prospective and Retrospective DUR Tables

Tables 1.1-1.2. Summary of Prospective DUR Alert Transactions in the Medi-Cal Fee-for-Service Program..

Table 1.1 provides summary level data (by volume) on pharmacy claims and DUR alert activities, including data and percent change from the prior quarter. Alerts are generated after adjudication of drug claims which exceed or otherwise fall outside of certain prescribed parameters. Please see **Appendix B** for definitions of terms used in this DUR report.

Category	Current Quarter 2018 Q3 (Jul – Sept 2018)	Prior Quarter 2018 Q2 (Apr – Jun 2018)	% Change from Prior Quarter	Prior-Year Quarter 2017 Q3 (Jul – Sept 2017)	% Change from Prior-Year Quarter
Drug Claims	7,656,519	7,872,048	-2.7%	7,743,453	-1.1%
DUR Drug Claims	3,712,001	3,807,244	-2.5%	3,781,914	-1.8%
Total Alerts	1,044,395	1,072,091	-2.6%	929,419	12.4%
Total Alert Overrides	666,064	678,835	-1.9%	555,708	19.9%
Total Alert Cancels	386	353	9.3%	157	145.9%

Note: Drug claims receiving multiple alerts can be adjudicated by pharmacists by responding to only one conflict code, followed by an intervention code and outcome code. The remaining alerts on the claim cannot be tracked as they are overridden by the pharmacist's response to a single alert. For example, a single claim can generate up to eight different alerts, but the pharmacist can override all eight alerts by choosing to override only one alert. In addition, the number of cancelled alerts may be underrepresented due to the system's inability to capture claims that were not adjudicated.

Table 1.2 provides a summary of the number of drug claims and alerts generated for each therapeutic problem type (sorted by alert frequency). Total alerts not adjudicated may be overrepresented, as claims with multiple alerts that have been adjudicated under one alert will show up as not adjudicated for the remaining alerts.

Therapeutic Problem Type	Total Alerts	Total Alert Overrides	% Alert Overrides	Total Alert Cancels	% Alert Cancels	Total Alerts Not Adjudicated	% Alerts Not Adjudicated
Therapeutic Duplication (TD)	377,626	284,225	75.3%	118	0.0%	93,283	24.7%
Early Refill (ER)	272,162	92,422	34.0%	129	0.0%	179,611	66.0%
Ingredient Duplication (ID)	165,044	119,283	72.3%	44	0.0%	45,717	27.7%
Late Refill (LR)	109,790	85,075	77.5%	56	0.1%	24,659	22.5%
Total High Dose (HD)	43,406	28,409	65.4%	11	0.0%	14,986	34.5%
Additive Toxicity (AT)	33,834	27,486	81.2%	10	0.0%	6,338	18.7%
Drug-Pregnancy (PG)	21,180	14,156	66.8%	6	0.0%	7,018	33.1%
Total Low Dose (LD)	11,602	7,789	67.1%	0	0.0%	3,813	32.9%
Drug-Drug (DD)	6,833	5,161	75.5%	2	0.0%	1,670	24.4%
Drug-Disease (MC)	2,479	1,752	70.7%	0	0.0%	727	29.3%
Drug-Allergy (DA)	292	213	72.9%	0	0.0%	79	27.1%
Drug-Age (PA)	147	93	63.3%	0	0.0%	54	36.7%

Tables 2.1-2.12. Prospective DUR Alert Transactions by Therapeutic Problem Type in the Medi-Cal Fee-for-Service Program.

Each of the following tables provides greater detail of each of the 12 DUR alerts with the top 10 drugs generating each respective alert. For each of the top 10 drugs, data are provided for the total number of adjudicated alerts, alert overrides, alert cancels, paid claims, and the percentage of paid claims with alert overrides. **Tables are listed in order of DUR alert priority, which is determined by the DUR Board.**

Table 2.1: Top 10 Drugs by Therapeutic Problem Type – Drug-Allergy (DA) – 2018 Q3						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	PHENYTOIN SODIUM EXTENDED	68	68	0	1,763	3.9%
2	PHENYTOIN	36	36	0	716	5.0%
3	OXYCODONE HCL	13	13	0	4,025	0.3%
4	IBUPROFEN	5	5	0	75,552	0.0%
5	AMOXICILLIN	4	4	0	29,614	0.0%
6	AMOXICILLIN/POTASSIUM CLAV	4	4	0	8,960	0.0%
7	OXYCODONE HCL/ACETAMINOPHEN	4	4	0	4,515	0.1%
8	ASPIRIN	3	3	0	50,764	0.0%
9	NAPROXEN	2	2	0	12,034	0.0%
10	ZIPRASIDONE HCL	2	2	0	16,808	0.0%

Table 2.2: Top 10 Drugs by Therapeutic Problem Type – Drug-Pregnancy (PG) – 2018 Q3						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	IBUPROFEN	13,819	13,816	3	75,552	18.3%
2	NORETHINDRONE	2,442	2,441	1	7,045	34.6%
3	MISOPROSTOL	364	364	0	507	71.8%
4	METHYLERGONOVINE MALEATE	303	303	0	152	199.3%
5	NAPROXEN	272	272	0	12,034	2.3%
6	ULIPRISTAL ACETATE	135	135	0	764	17.7%
7	METHIMAZOLE	101	101	0	1,464	6.9%
8	LISINOPRIL	98	98	0	31,393	0.3%
9	INDOMETHACIN	87	87	0	815	10.7%
10	PROPRANOLOL HCL	69	68	1	4,139	1.6%

Table 2.3: Top 10 Drugs by Therapeutic Problem Type – Drug-Disease (MC) – 2018 Q3						
Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	METFORMIN HCL	453	453	0	40,408	1.1%
2	POTASSIUM CHLORIDE	423	421	2	3,262	12.9%
3	HALOPERIDOL	299	299	0	20,846	1.4%
4	METOPROLOL TARTRATE	67	67	0	7,159	0.9%
5	CARBAMAZEPINE	56	56	0	2,919	1.9%
6	METOPROLOL SUCCINATE	51	51	0	5,786	0.9%
7	LEVONORGESTREL-ETHIN ESTRADIOL	48	48	0	17,687	0.3%
8	NORELGESTROMIN/ETHIN. ESTRADIOL	47	47	0	9,456	0.5%
9	NORETHINDRONE-E. ESTRADIOL-IRON	43	43	0	15,902	0.3%
10	HALOPERIDOL DECANOATE	42	42	0	4,303	1.0%

Table 2.4: Top 10 Drugs by Therapeutic Problem Type – Drug-Drug Interaction (DD) – 2018 Q3

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	ELVITEG/COB/EMTRI/TENOF ALAFEN	722	722	0	13,350	5.4%
2	DARUNAVIR ETHANOLATE	606	605	1	3,871	15.6%
3	GEMFIBROZIL	551	550	1	2,305	23.9%
4	ATORVASTATIN CALCIUM	336	336	0	29,473	1.1%
5	SIMVASTATIN	257	257	0	9,463	2.7%
6	DARUNAVIR/COBICISTAT	179	179	0	5,390	3.3%
7	AMLODIPINE BESYLATE	168	168	0	21,283	0.8%
8	ETRAVIRINE	148	148	0	805	18.4%
9	BUPRENORPHINE HCL/ NALOXONE HCL	113	113	0	36,096	0.3%
10	LURASIDONE HCL	112	112	0	40,224	0.3%

Table 2.5: Top 10 Drugs by Therapeutic Problem Type – Therapeutic Duplication (TD) – 2018 Q3

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	70,230	70,202	28	137,972	50.9%
2	OLANZAPINE	26,135	26,128	7	78,422	33.3%
3	ARIPIPIRAZOLE	23,372	23,359	13	103,392	22.6%
4	RISPERIDONE	20,708	20,704	4	81,703	25.3%
5	HALOPERIDOL	14,533	14,528	5	20,846	69.7%
6	LURASIDONE HCL	12,379	12,372	7	40,224	30.8%
7	CLOZAPINE	11,418	11,416	2	20,554	55.5%
8	PALIPERIDONE PALMITATE	7,329	7,328	1	18,578	39.4%
9	ZIPRASIDONE HCL	5,261	5,260	1	16,808	31.3%
10	CHLORPROMAZINE HCL	4,946	4,946	0	5,887	84.0%

Table 2.6: Top 10 Drugs by Therapeutic Problem Type – Overutilization (ER) – 2018 Q3

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	QUETIAPINE FUMARATE	6,853	6,844	9	137,972	5.0%
2	ARIPIPIRAZOLE	5,911	5,903	8	103,392	5.7%
3	RISPERIDONE	4,589	4,584	5	81,703	5.6%
4	OLANZAPINE	4,386	4,384	2	78,422	5.6%
5	BENZTROPINE MESYLATE	3,989	3,988	1	54,913	7.3%
6	LITHIUM CARBONATE	2,699	2,698	1	29,845	9.0%
7	LURASIDONE HCL	2,090	2,090	0	40,224	5.2%
8	ASPIRIN	2,083	2,082	1	50,764	4.1%
9	METFORMIN HCL	1,875	1,872	3	40,408	4.6%
10	BUPRENORPHINE HCL/ NALOXONE HCL	1,868	1,868	0	36,096	5.2%

Table 2.7: Top 10 Drugs by Therapeutic Problem Type – Underutilization (LR) – 2018 Q3

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	ARIPRAZOLE	14,237	14,226	11	103,392	13.8%
2	QUETIAPINE FUMARATE	13,182	13,172	10	137,972	9.5%
3	RISPERIDONE	8,654	8,653	1	81,703	10.6%
4	OLANZAPINE	7,184	7,178	6	78,422	9.2%
5	BENZTROPINE MESYLATE	6,702	6,698	4	54,913	12.2%
6	LURASIDONE HCL	5,036	5,034	2	40,224	12.5%
7	LITHIUM CARBONATE	4,089	4,088	1	29,845	13.7%
8	ATORVASTATIN CALCIUM	3,013	3,011	2	29,473	10.2%
9	LEVOTHYROXINE SODIUM	2,726	2,722	4	24,601	11.1%
10	GABAPENTIN	2,541	2,540	1	23,240	10.9%

Table 2.8: Top 10 Drugs by Therapeutic Problem Type – Additive Toxicity (AT) – 2018 Q3

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	LITHIUM CARBONATE	1,482	1,481	1	29,845	5.0%
2	LORAZEPAM	1,425	1,424	1	8,141	17.5%
3	CLONAZEPAM	1,163	1,163	0	6,549	17.8%
4	BACLOFEN	1,132	1,132	0	13,319	8.5%
5	HYDROCODONE/ACETAMINOPHEN	1,109	1,109	0	29,390	3.8%
6	QUETIAPINE FUMARATE	754	754	0	137,972	0.5%
7	ARIPRAZOLE	645	645	0	103,392	0.6%
8	BUSPIRONE HCL	550	550	0	3,432	16.0%
9	OLANZAPINE	538	538	0	78,422	0.7%
10	ZOLPIDEM TARTRATE	497	497	0	2,844	17.5%

Table 2.9: Top 10 Drugs by Therapeutic Problem Type – Ingredient Duplication (ID) – 2018 Q3

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	OLANZAPINE	14,091	14,086	5	78,422	18.0%
2	ARIPRAZOLE	12,191	12,188	3	103,392	11.8%
3	RISPERIDONE	11,065	11,062	3	81,703	13.5%
4	ALBUTEROL SULFATE	6,484	6,483	1	34,709	18.7%
5	LURASIDONE HCL	5,837	5,833	4	40,224	14.5%
6	CLOZAPINE	5,616	5,616	0	20,554	27.3%
7	ZIPRASIDONE HCL	3,220	3,218	2	16,808	19.1%
8	LEVOTHYROXINE SODIUM	3,103	3,103	0	24,601	12.6%
9	BENZTROPINE MESYLATE	2,579	2,578	1	54,913	4.7%
10	HALOPERIDOL	2,524	2,523	1	20,846	12.1%

Table 2.10: Top 10 Drugs by Therapeutic Problem Type – Drug-Age (PA) – 2018 Q3

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	AMITRIPTYLINE HCL	142	142	0	3,036	4.7%
2	ACETAMINOPHEN WITH CODEINE	64	64	0	6,957	0.9%
3	CODEINE PHOSPHATE/GUAIFENESIN	16	16	0	1,978	0.8%
4	CABERGOLINE	5	5	0	80	6.3%
5	DOXEPIN HCL	5	5	0	418	1.2%
6	ESTRADIOL	4	4	0	1,053	0.4%
7	LEVETIRACETAM	4	4	0	16,544	0.0%
8	OLANZAPINE	4	4	0	78,422	0.0%
9	BENZTROPINE MESYLATE	3	3	0	54,913	0.0%
10	LIPASE/PROTEASE/AMYLASE	3	3	0	2,132	0.1%

Table 2.11: Top 10 Drugs by Therapeutic Problem Type – High Dose (HD) – 2018 Q3

Rank	Drug Generic Name/Ingredient Name	Total Adjudicated Alerts	Total Alert Overrides	Total Alert Cancels	Total Paid Claims	% of Paid Claims with Alert Overrides
1	OLANZAPINE	6,774	6,772	2	78,422	8.6%
2	RISPERIDONE	2,313	2,313	0	81,703	2.8%
3	QUETIAPINE FUMARATE	1,596	1,595	1	137,972	1.2%
4	HYDROCODONE/ACETAMINOPHEN	1,349	1,349	0	29,390	4.6%
5	GABAPENTIN	1,283	1,283	0	23,240	5.5%
6	IBUPROFEN	1,153	1,152	1	75,552	1.5%
7	ARIPIPIRAZOLE	601	601	0	103,392	0.6%
8	AMOXICILLIN	539	539	0	29,614	1.8%
9	AMOXICILLIN/POTASSIUM CLAV	485	485	0	8,960	5.4%
10	FAMOTIDINE	482	482	0	13,444	3.6%

Table 2.12: Top 10 Drugs by Therapeutic Problem Type – Low Dose (LD) – 2018 Q3

Rank	Rank	Rank	Rank	Rank	Rank	Rank
1	AZITHROMYCIN	968	968	0	14,741	6.6%
2	DIVALPROEX SODIUM	756	756	0	11,024	6.9%
3	AMOXICILLIN	482	482	0	29,614	1.6%
4	ERYTHROMYCIN ETHYLSUCCINATE	424	424	0	1,747	24.3%
5	DULOXETINE HCL	378	378	0	3,912	9.7%
6	BUPROPION HCL	349	349	0	5,885	5.9%
7	AMOXICILLIN/POTASSIUM CLAV	282	282	0	8,960	3.1%
8	SULFAMETHOXAZOLE/TRIMETHOPRIM	246	246	0	16,695	1.5%
9	LITHIUM CARBONATE	207	207	0	29,845	0.7%
10	ALBUTEROL SULFATE	161	161	0	34,709	0.5%

Tables 3.1-3.3. Summary of Medi-Cal Fee-for-Service Pharmacy Utilization.

These tables show pharmacy utilization in the Medi-Cal Fee-for-Service program, including the percent change from the prior quarter and prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 3.2** and **Table 3.3**, as enrollment status may change.

Table 3.1: Fee-for-Service Pharmacy Utilization Measures for the Entire Medi-Cal Population					
Category	Current Quarter 2018 Q3	Prior Quarter 2018 Q2	Prior-Year Quarter 2017 Q3	% Change from <i>Prior</i> Quarter	% Change from <i>Prior- Year</i> Quarter
Total Eligible Beneficiaries	15,701,037	15,659,928	16,074,352	0.3%	-2.3%
Total Utilizing Beneficiaries	790,535	810,406	830,545	-2.5%	-4.8%
Total Paid Rx Claims	2,621,898	2,714,000	2,733,078	-3.4%	-4.1%
Average Paid Rx Claims per Eligible Beneficiary	0.17	0.17	0.17	-3.6%	-1.8%
Average Paid Rx Claims per Utilizing Beneficiary	3.32	3.35	3.29	-1.0%	0.8%

Table 3.2: Fee-for-Service Pharmacy Utilization Measures for the Medi-Cal FFS Population Only					
Category	Current Quarter 2018 Q3	Prior Quarter 2018 Q2	Prior-Year Quarter 2017 Q3	% Change from <i>Prior</i> Quarter	% Change from <i>Prior- Year</i> Quarter
Total Eligible Beneficiaries	3,146,681	3,188,545	3,334,130	-1.3%	-5.6%
Total Utilizing Beneficiaries	444,049	458,224	468,803	-3.1%	-5.3%
Total Paid Rx Claims	1,569,117	1,634,254	1,656,876	-4.0%	-5.3%
Average Paid Rx Claims per Eligible Beneficiary	0.50	0.51	0.50	-2.7%	0.3%
Average Paid Rx Claims per Utilizing Beneficiary	3.53	3.57	3.53	-0.9%	0.0%

Table 3.3: Fee-for-Service Pharmacy Utilization Measures for the Medi-Cal MCP Population Only					
Category	Current Quarter 2018 Q3	Prior Quarter 2018 Q2	Prior-Year Quarter 2017 Q3	% Change from <i>Prior</i> Quarter	% Change from <i>Prior- Year</i> Quarter
Total Eligible Beneficiaries	12,966,481	12,892,703	13,190,630	0.6%	-1.7%
Total Utilizing Beneficiaries	274,288	274,969	269,824	-0.2%	1.7%
Total Paid Rx Claims	910,740	927,071	898,912	-1.8%	1.3%
Average Paid Rx Claims per Eligible Beneficiary	0.07	0.07	0.07	-2.3%	3.1%
Average Paid Rx Claims per Utilizing Beneficiary	3.32	3.37	3.33	-1.5%	-0.3%

Tables 4.1-4.3. Fee-for-Service Pharmacy Utilization by Age Group in the Medi-Cal Population.

These tables present pharmacy utilization data in the Medi-Cal Fee-for-Service program, broken out by age group, including the percent change from the prior quarter and prior-year quarter. Beneficiaries with enrollments in both FFS and MCP during the quarter may be counted in both **Table 4.2** and **Table 4.3**, as enrollment status may change.

Table 4.1: Fee-for-Service Pharmacy Utilization by Age Group for the Entire Medi-Cal Population						
Age Group (years)	Current Quarter 2018 Q3 Total Paid Claims	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>	Current Quarter Total Utilizing Beneficiaries	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>
0 – 12	258,884	-10.3%	-12.3%	82,443	-8.5%	-14.3%
13 – 18	174,353	-3.5%	-4.0%	45,169	-1.6%	-3.5%
19 – 39	804,760	-1.6%	-1.3%	262,513	-0.8%	-1.7%
40 – 64	1,094,790	-2.5%	-2.3%	279,273	-1.1%	-1.0%
65+	198,266	-3.9%	-5.7%	65,534	-3.9%	-7.0%
Total*	2,621,898	-3.4%	-4.1%	790,535	-2.5%	-4.8%

Table 4.2: Fee-for-Service Pharmacy Utilization by Age Group for the Medi-Cal FFS Population Only						
Age Group (years)	Current Quarter 2018 Q3 Total Paid Claims	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>	Current Quarter Total Utilizing Beneficiaries	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>
0 – 12	153,398	-12.0%	-15.1%	60,418	-9.3%	-15.9%
13 – 18	90,305	-2.4%	-5.5%	24,239	-0.3%	-5.3%
19 – 39	460,776	-2.4%	-4.2%	151,169	-1.3%	-3.3%
40 – 64	675,694	-3.2%	-3.2%	145,997	-2.1%	-1.2%
65+	188,944	-4.2%	-6.3%	62,226	-4.2%	-7.5%
Total*	1,569,117	-4.0%	-5.3%	444,049	-3.1%	-5.3%

Table 4.3: Fee-for-Service Pharmacy Utilization by Age Group for the Medi-Cal MCP Population Only						
Age Group (years)	Current Quarter 2018 Q3 Total Paid Claims	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>	Current Quarter Total Utilizing Beneficiaries	% Change from <i>Prior Quarter</i>	% Change from <i>Prior-Year Quarter</i>
0 – 12	92,146	-5.7%	-3.6%	20,106	-4.0%	-4.9%
13 – 18	79,466	-3.8%	-0.8%	20,540	-2.8%	-0.6%
19 – 39	323,200	-0.5%	5.6%	101,946	1.0%	5.5%
40 – 64	406,916	-1.5%	-0.5%	128,487	-0.2%	0.1%
65+	9,012	0.3%	7.1%	3,209	-0.1%	6.4%
Total*	910,740	-1.8%	1.3%	274,288	-0.2%	1.7%

* Unknowns represent less than 1% of total

Tables 5.1-5.3. Top 20 Fee-for-Service Drug Therapeutic Categories in the Medi-Cal Population.

These tables present utilization of the top 20 drug therapeutic categories in the Medi-Cal Fee-for-Service program, by **total utilizing beneficiaries**. The current quarter is compared to the prior quarter and prior-year quarter in order to illustrate changes in utilization and reimbursement dollars paid to pharmacies for these top utilized drugs. The prior-year quarter ranking of the drug therapeutic category is listed for reference.

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2018 Q3 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST	405,221	-1.4%	0.3%	138,055	17.5%	0.2%	0.8%
2	2	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	93,351	-2.8%	-5.5%	79,915	10.1%	0.0%	-0.1%
3	3	CONTRACEPTIVES, ORAL	78,331	-3.8%	-10.2%	59,093	7.5%	-0.1%	-0.6%
4	4	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	108,945	-0.6%	3.4%	47,237	6.0%	0.1%	0.4%
5	5	PENICILLIN ANTIBIOTICS	42,914	-13.7%	-7.4%	38,641	4.9%	-0.6%	-0.2%
6	6	PLATELET AGGREGATION INHIBITORS	52,819	-5.4%	-15.1%	35,569	4.5%	-0.1%	-0.5%
7	7	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	40,862	-2.2%	-20.9%	32,960	4.2%	0.0%	-0.8%
8	8	ANTICONVULSANTS	85,612	-3.0%	-1.7%	32,219	4.1%	0.0%	0.1%
9	9	IRON REPLACEMENT	39,618	-1.8%	-7.4%	29,625	3.7%	0.0%	-0.2%
10	10	LAXATIVES AND CATHARTICS	45,226	-0.6%	-10.0%	29,483	3.7%	0.1%	-0.3%
11	12	ANTIHYPERTENSIVE - HMG COA REDUCTASE INHIBITORS	43,890	-3.4%	3.4%	28,789	3.6%	0.0%	0.3%
12	11	ANTIHYPERTENSIVES, ACE INHIBITORS	43,025	-4.9%	-3.5%	28,044	3.5%	-0.1%	0.1%
13	14	ANTIHYPERTENSIVE, BIGUANIDE TYPE	40,408	-2.4%	-0.2%	26,750	3.4%	0.0%	0.2%
14	13	ANTIHISTAMINES - 2ND GENERATION	38,047	-16.5%	-9.6%	24,464	3.1%	-0.7%	-0.2%
15	16	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	25,853	4.2%	-3.3%	24,277	3.1%	0.2%	0.0%
16	15	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	36,182	-13.6%	-7.2%	23,880	3.0%	-0.5%	-0.2%
17	17	ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC	60,030	-1.8%	-2.0%	23,497	3.0%	0.0%	0.0%
18	19	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	36,241	-2.1%	-3.0%	20,087	2.5%	0.0%	0.0%
19	18	PRENATAL VITAMIN PREPARATIONS	22,059	-12.6%	-16.0%	19,569	2.5%	-0.3%	-0.3%
20	20	TOPICAL ANTI-INFLAMMATORY STEROIDAL	23,272	-2.1%	-7.3%	19,211	2.4%	0.0%	-0.1%

Table 5.2: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Medi-Cal FFS Population Only

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2018 Q3 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE ANALGESICS	91,830	-2.5%	-4.8%	80,564	18.1%	-2.5%	-5.1%
2	2	PENICILLIN ANTIBIOTICS	41,796	-13.5%	-6.8%	38,716	8.7%	-13.6%	-7.2%
3	4	PLATELET AGGREGATION INHIBITORS	51,635	-5.4%	-15.1%	35,419	8.0%	-5.3%	-14.3%
4	3	OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS	40,041	-2.0%	-20.2%	33,301	7.5%	-1.8%	-19.6%
5	5	ANTICONVULSANTS	68,787	-3.1%	-2.9%	33,124	7.5%	-1.7%	-2.6%
6	7	IRON REPLACEMENT	38,013	-0.8%	-2.3%	28,530	6.4%	-0.7%	-2.8%
7	8	ANTIHYPERLIPIDEMIC - HMG COA REDUCTASE INHIBITORS	43,219	-3.3%	3.5%	28,523	6.4%	-3.0%	3.9%
8	6	LAXATIVES AND CATHARTICS	42,514	-0.4%	-9.5%	28,386	6.4%	0.3%	-10.1%
9	9	ANTIHYPERTENSIVES, ACE INHIBITORS	39,483	-4.9%	-3.3%	26,207	5.9%	-4.4%	-2.8%
10	11	ANTIHYPERGLYCEMIC, BIGUANIDE TYPE	38,083	-2.1%	0.6%	25,518	5.8%	-1.8%	1.0%
11	10	ANTI HISTAMINES - 2ND GENERATION	36,970	-16.6%	-9.7%	23,928	5.4%	-19.5%	-10.1%
12	13	CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION	24,556	4.7%	-1.4%	23,095	5.2%	4.3%	-1.4%
13	12	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	32,312	-14.8%	-8.1%	22,260	5.0%	-16.6%	-10.0%
14	15	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	35,562	-2.2%	-2.8%	20,006	4.5%	-1.7%	-3.6%
15	17	PRENATAL VITAMIN PREPARATIONS	21,526	-10.6%	-4.0%	19,715	4.4%	-7.4%	0.2%
16	14	TOPICAL ANTI-INFLAMMATORY STEROIDAL	22,618	-1.7%	-6.8%	19,628	4.4%	-1.6%	-6.8%
17	16	ANTI HISTAMINES – 1ST GENERATION	25,459	-3.8%	-8.0%	18,569	4.2%	-2.8%	-7.4%
18	19	ANTIEMETIC/ANTIVERTIGO AGENTS	21,313	0.7%	-0.0%	17,898	4.0%	0.4%	1.3%
19	18	INSULINS	30,603	-3.3%	-3.8%	17,464	3.9%	-3.4%	-4.0%
20	20	CALCIUM CHANNEL BLOCKING AGENTS	24,930	-3.2%	2.2%	16,000	3.6%	-2.4%	3.5%

Table 5.3: Top 20 Fee-for-Service Drug Therapeutic Categories by *Total Utilizing Beneficiaries* for the Medi-Cal MCP Population Only

Rank	Last Year Rank	Drug Therapeutic Category Description	Current Quarter 2018 Q3 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	ANTIPSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST	369,729	-1.2%	0.8%	141,948	51.8%	-1.1%	-0.3%
2	2	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	100,617	-0.5%	3.8%	43,901	16.0%	-0.1%	2.5%
3	3	ANTIPARKINSONISM DRUGS, ANTICHOLINERGIC	54,868	-1.5%	-1.7%	21,569	7.9%	-1.6%	-3.7%
4	7	NARCOTIC WITHDRAWAL THERAPY AGENTS	39,740	4.3%	31.5%	12,422	4.5%	4.1%	24.4%
5	4	BIPOLAR DISORDER DRUGS	27,628	-1.9%	-0.8%	11,451	4.2%	-3.2%	-3.0%
6	5	INSULINS	21,541	-5.2%	-9.1%	10,846	4.0%	-4.7%	-6.5%
7	6	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	23,888	-4.4%	2.0%	10,835	4.0%	-4.3%	3.4%
8	8	ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES	23,404	-2.0%	0.6%	8,973	3.3%	-1.1%	-1.2%
9	10	ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS	19,289	13.3%	47.8%	8,111	3.0%	10.1%	49.6%
10	9	ANTICONVULSANTS	16,524	-2.7%	4.0%	6,796	2.5%	-2.6%	2.6%
11	16	NARCOTIC ANTAGONISTS	8,728	8.0%	65.2%	6,412	2.3%	11.7%	78.9%
12	12	ANTIVIRALS, HIV-1 INTEGRASE STRAND TRANSFER INHIBITR	11,620	-6.8%	-1.9%	4,897	1.8%	-6.3%	-0.2%
13	11	ANTIPSYCHOTICS, PHENOTHIAZINES	12,152	-3.9%	-5.6%	4,597	1.7%	-4.6%	-7.2%
14	13	ANTIRETROVIRAL-NRTIS AND INTEGRASE INHIBITORS COMB	10,089	-5.8%	-3.8%	4,099	1.5%	-5.6%	-2.1%
15	15	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	8,252	-4.6%	-10.8%	3,332	1.2%	-6.3%	-11.5%
16	14	ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB	7,833	-8.4%	-19.3%	3,228	1.2%	-7.5%	-19.2%
17	18	ANALGESICS, NARCOTICS	5,742	-1.7%	-2.8%	2,962	1.1%	0.1%	-5.5%
18	17	ANTIVIRALS, HIV-SPECIFIC, PROTEASE INHIBITORS	5,829	-10.6%	-33.5%	2,355	0.9%	-11.1%	-34.0%
19	19	ANTIVIRALS, HIV-SPECIFIC, NUCLEOTIDE ANALOG, RTI	4,915	-6.0%	-29.1%	2,223	0.8%	-6.4%	-28.0%
20	21	ANTICONVULSANT – BENZODIAZEPINE TYPE	4,655	0.7%	14.3%	2,159	0.8%	4.4%	15.6%

Tables 6.1-6.3. Top 20 Fee-for-Service Drugs in the Medi-Cal Population.

These tables present the utilization of the top 20 drugs in the Medi-Cal Fee-for-Service program, by **total utilizing beneficiaries**. The current quarter is compared to the prior quarter and prior-year quarter in order to illustrate changes in utilization for these drugs. The prior-year quarter ranking of each drug is listed for reference.

Table 6.1: Top 20 Fee-for-Service Drugs by Total Utilizing Beneficiaries for the Entire Medi-Cal Population

Rank	Last Year Rank	Drug Description	Current Quarter 2018 Q3 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	IBUPROFEN	75,552	-2.7%	-5.4%	66,963	8.5%	0.0%	-0.1%
2	2	QUETIAPINE FUMARATE	137,972	-1.2%	0.0%	53,237	6.7%	0.1%	0.2%
3	3	ARIPIRAZOLE	103,392	-0.8%	2.1%	45,081	5.7%	0.1%	0.3%
4	4	ASPIRIN	50,764	-5.6%	-17.0%	34,847	4.4%	-0.1%	-0.6%
5	5	RISPERIDONE	81,703	-2.1%	-2.9%	32,925	4.2%	0.0%	0.1%
6	10	OLANZAPINE	78,422	-0.9%	2.4%	30,001	3.8%	0.0%	0.2%
7	6	FERROUS SULFATE	39,508	-1.8%	-7.5%	29,580	3.7%	0.0%	-0.2%
8	9	AMOXICILLIN	29,614	-14.8%	-8.3%	27,177	3.4%	-0.5%	-0.1%
9	12	METFORMIN HCL	40,408	-2.4%	-0.2%	26,750	3.4%	0.0%	0.2%
10	8	DOCUSATE SODIUM	39,427	-0.3%	-10.4%	26,662	3.4%	0.1%	-0.3%
11	7	HYDROCODONE/ACETAMINOPHEN	29,390	-0.6%	-20.0%	24,371	3.1%	0.1%	-0.6%
12	14	CEPHALEXIN	25,728	3.8%	-3.5%	24,251	3.1%	0.2%	0.0%
13	11	LORATADINE	36,696	-16.9%	-10.2%	23,853	3.0%	-0.6%	-0.2%
14	13	ALBUTEROL SULFATE	34,709	-15.0%	-8.5%	23,513	3.0%	-0.5%	-0.2%
15	15	BENZTROPINE MESYLATE	54,913	-1.6%	-1.7%	21,629	2.7%	0.0%	0.0%
16	16	LISINOPRIL	31,393	-5.2%	-1.6%	21,022	2.7%	-0.1%	0.1%
17	18	ATORVASTATIN CALCIUM	29,473	-1.7%	13.4%	19,349	2.4%	0.0%	0.4%
18	20	LURASIDONE HCL	40,224	-0.7%	3.8%	17,023	2.2%	0.0%	0.2%
19	17	METRONIDAZOLE	17,312	-2.0%	-9.0%	16,178	2.0%	0.0%	-0.1%
20	19	FOLIC ACID	25,760	-3.8%	-9.9%	15,072	1.9%	0.0%	-0.1%

Table 6.2: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Medi-Cal FFS Population Only

Rank	Last Year Rank	Drug Description	Current Quarter 2018 Q3 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	IBUPROFEN	74,510	-2.5%	-4.5%	66,039	14.9%	-2.4%	-5.0%
2	2	ASPIRIN	49,657	-5.5%	-17.1%	34,263	7.7%	-5.5%	-16.1%
3	3	FERROUS SULFATE	37,959	-0.8%	-2.3%	28,501	6.4%	-0.8%	-2.9%
4	6	AMOXICILLIN	28,978	-14.8%	-7.8%	26,719	6.0%	-14.8%	-8.1%
5	5	DOCUSATE SODIUM	38,748	-0.2%	-9.5%	26,139	5.9%	0.3%	-10.3%
6	8	METFORMIN HCL	38,083	-2.1%	0.6%	25,518	5.8%	-1.8%	1.0%
7	4	HYDROCODONE/ ACETAMINOPHEN	28,690	-0.5%	-19.6%	23,798	5.4%	0.1%	-18.8%
8	7	LORATADINE	36,090	-16.9%	-10.2%	23,514	5.3%	-19.7%	-10.4%
9	10	CEPHALEXIN	24,444	4.3%	-1.6%	23,072	5.2%	4.3%	-1.4%
10	9	ALBUTEROL SULFATE	31,857	-16.0%	-9.0%	22,236	5.0%	-17.9%	-11.0%
11	11	LISINOPRIL	30,121	-5.1%	-1.4%	20,275	4.6%	-4.4%	-0.5%
12	12	ATORVASTATIN CALCIUM	29,014	-1.5%	13.8%	19,041	4.3%	-1.3%	13.9%
13	14	FOLIC ACID	24,881	-2.7%	-4.6%	14,462	3.3%	-3.0%	-2.2%
14	17	AMLODIPINE BESYLATE	20,606	-3.1%	3.4%	13,283	3.0%	-2.4%	5.3%
15	15	GABAPENTIN	22,341	-1.0%	3.3%	13,091	3.0%	0.5%	1.7%
16	13	ACETAMINOPHEN	13,003	-10.6%	-20.6%	12,310	2.8%	-9.9%	-20.2%
17	18	LEVOTHYOXINE SODIUM	21,151	-2.1%	-3.7%	12,254	2.8%	-1.6%	-2.7%
18	19	ONDANSETRON HCL	13,859	0.9%	0.1%	11,856	2.7%	0.4%	1.0%
19	20	PRENATAL VITAMIN NO. 95/FERROUS FUM/FOLIC ACID	13,202	66.2%	77.5%	11,833	2.7%	69.5%	79.8%
20	16	SULFAMETHOXAZOLE/ TRIMETHOPRIM	13,372	5.6%	-7.8%	11,741	2.6%	6.5%	-7.4%

Table 6.3: Top 20 Fee-for-Service Drugs by *Total Utilizing Beneficiaries* for the Medi-Cal MCP Population Only

Rank	Last Year Rank	Drug Description	Current Quarter 2018 Q3 Total Paid Claims	% Change from Prior Quarter	% Change from Prior-Year Quarter	Current Quarter Total Utilizing Beneficiaries	% Utilizing Beneficiaries with a Paid Claim	% Change Total Utilizing Beneficiaries from Prior Quarter	% Change Utilizing Total Utilizing Beneficiaries Prior-Year Quarter
1	1	QUETIAPINE FUMARATE	126,798	-1.2%	0.2%	48,899	17.8%	-1.2%	-1.4%
2	2	ARIPIRAZOLE	95,228	-0.7%	2.4%	41,518	15.1%	-0.4%	1.1%
3	3	RISPERIDONE	72,684	-1.9%	-2.2%	29,391	10.7%	-1.8%	-2.9%
4	4	OLANZAPINE	70,618	-0.5%	2.7%	27,016	9.9%	-0.8%	2.0%
5	5	BENZTROPINE MESYLATE	50,327	-1.2%	-1.4%	19,813	7.2%	-1.3%	-3.6%
6	6	LURASIDONE HCL	37,912	-0.5%	4.3%	16,065	5.9%	-0.8%	3.1%
7	7	LITHIUM CARBONATE	27,322	-1.9%	-0.9%	11,333	4.1%	-3.3%	-3.0%
8	8	BUPRENORPHINE HCL/NALOXONE HCL	33,549	4.6%	33.2%	10,115	3.7%	4.5%	25.8%
9	10	PALIPERIDONE PALMITATE	17,669	2.1%	14.3%	7,506	2.7%	3.0%	14.3%
10	9	HALOPERIDOL	18,918	-2.3%	-0.3%	7,199	2.6%	-1.5%	-2.0%
11	12	EMTRICITABINE/TENOFOVIR (TDF)	12,518	-2.8%	-2.8%	6,250	2.3%	-2.3%	-0.1%
12	11	ZIPRASIDONE HCL	15,636	-3.4%	-8.0%	5,808	2.1%	-4.0%	-10.4%
13	14	ELVITEG/COB/EMTRI/TENOF ALAFEN	11,802	-6.5%	3.6%	4,837	1.8%	-7.4%	3.4%
14	16	EMTRICITABINE/TENOFOV ALAFENAM	11,370	-6.2%	7.9%	4,585	1.7%	-6.8%	8.5%
15	15	INSULIN LISPRO	9,030	-4.1%	-6.2%	4,259	1.6%	-3.3%	-3.1%
16	13	INSULIN GLARGINE, HUM.REC.ANALOG	7,550	-7.4%	-17.1%	4,145	1.5%	-6.3%	-13.3%
17	17	ABACAVIR/DOLUTEGRAVIR/LAMIVUDI	10,089	-5.8%	-3.8%	4,099	1.5%	-5.6%	-2.1%
18	18	DOLUTEGRAVIR SODIUM	9,381	-5.8%	5.3%	3,882	1.4%	-5.8%	6.7%
19	20	NALTREXONE HCL	5,535	3.0%	32.8%	3,355	1.2%	4.6%	32.2%
20	19	CLOZAPINE	18,151	-2.2%	2.9%	3,287	1.2%	0.9%	5.1%

Tables 7.1-7.2. Summary of Generic Drug Utilization – FFY 2018 (October 1, 2017 through September 30, 2018)

The Centers for Medicare & Medicaid Services (CMS) developed an extract file from the Medicaid Drug Rebate Program Drug Product Data File identifying each National Drug Code (NDC) along with sourcing status: S, N, or I (see key below). This file was made available from CMS to facilitate consistent reporting and contains the active drugs that have been reported by participating manufacturers as of the most recent rebate reporting period under the Medicaid Drug Rebate Program. **Table 7.1** presents a utilization summary of drugs by sourcing status over the last Federal Fiscal Year (FFY 2018), with the current FFY compared to the previous FFY (FFY 2017) in order to show any changes in utilization. **Table 7.2** presents the top 10 drugs in each source code category, by total utilizing beneficiaries.

Table 7.1: Drug Utilization by Source Code – FFY 2018								
Single-Source (S) Drugs			Non-Innovator (N) Drugs			Innovator Multi-Source (I) Drugs		
Total Number of Claims	% Change Total Number of Claims from <i>Prior Year</i>	Total Reimbursement Amount Less Co-Pay	Total Number of Claims	% Change Total Number of Claims from <i>Prior Year</i>	Total Reimbursement Amount Less Co-Pay	Total Number of Claims	% Change Total Number of Claims from <i>Prior Year</i>	Total Reimbursement Amount Less Co-Pay
1,703,731	0.8%	\$2,766,806,174	7,598,080	-4.7%	\$266,496,188	957,215	-6.7%	\$619,150,812

- Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market
- Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market
- Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity

Table 7.2. Top 10 Drugs in each Source Code by Total Utilizing Beneficiaries – FFY 2018

Single-Source (S) - Drugs that have an FDA New Drug Application (NDA) approval for which there are no generic alternatives available on the market					
NDC	Drug Description	Product Label Name	Total Reimbursement Dollars Paid to Pharmacies	Total Utilizing Beneficiaries	Total Paid Claims
59310057922	ALBUTEROL SULFATE	PROAIR HFA 90 MCG INHALER	\$8,335,567	76,900	119,354
00088222033	INSULIN GLARGINE,HUM.REC.ANLOG	LANTUS 100 UNIT/ML VIAL	\$25,029,923	19,346	66,852
63402030430	LURASIDONE HCL	LATUDA 40 MG TABLET	\$58,400,853	13,349	44,888
51285016288	LEVONORGESTREL	PLAN B ONE-STEP 1.5 MG TABLET	\$584,834	12,797	14,918
12496120803	BUPRENORPHINE HCL/NALOXONE HCL	SUBOXONE 8 MG-2 MG SL FILM	\$28,765,676	12,712	87,987
00002751001	INSULIN LISPRO	HUMALOG 100 UNITS/ML VIAL	\$20,214,010	12,275	42,736
61958070101	EMTRICITABINE/TENOFOVIR (TDF)	TRUVADA 200 MG-300 MG TABLET	\$93,743,470	12,128	54,597
63402030230	LURASIDONE HCL	LATUDA 20 MG TABLET	\$43,818,762	11,027	33,063
00430042014	NORETHINDRONE-E.ESTRADIOL-IRON	LO LOESTRIN FE 1-10 TABLET	\$7,253,320	10,370	24,580
00052027303	ETONOGESTREL/ETHINYL ESTRADIOL	NUVARING VAGINAL RING	\$8,751,326	10,045	24,097
Non-Innovator Multiple-Source (N) - Drugs that have an FDA Abbreviated New Drug Application (ANDA) approval and for which there exists generic alternatives on the market					
NDC	Drug Description	Product Label Name	Total Reimbursement Dollars Paid to Pharmacies	Total Utilizing Beneficiaries	Total Paid Claims
55111068305	IBUPROFEN	IBU 600 MG TABLET	\$404,004	40,076	44,907
00603158658	PROMETHAZINE/ DEXTROMETHORPHAN	PROMETHAZINE-DM SOLUTION	\$404,518	30,379	40,716
55111068405	IBUPROFEN	IBU 800 MG TABLET	\$320,432	28,737	34,221
68180012202	CEPHALEXIN	CEPHALEXIN 500 MG CAPSULE	\$304,503	28,595	31,167
00406012301	HYDROCODONE/ ACETAMINOPHEN	HYDROCODONE-ACETAMIN 5-325 MG	\$322,008	28,472	34,414
65862001705	AMOXICILLIN	AMOXICILLIN 500 MG CAPSULE	\$283,182	27,507	31,354
45802065087	LORATADINE	LORATADINE 10 MG TABLET	\$643,715	27,183	68,585
67877032105	IBUPROFEN	IBUPROFEN 800 MG TABLET	\$301,746	26,034	31,740
00781261305	AMOXICILLIN	AMOXICILLIN 500 MG CAPSULE	\$260,636	25,205	28,825
67877032005	IBUPROFEN	IBUPROFEN 600 MG TABLET	\$256,647	25,170	28,826
Innovator Multiple-Source (I) - Drugs which have an NDA and no longer have patent exclusivity					
NDC	Drug Description	Product Label Name	Total Reimbursement Dollars Paid to Pharmacies	Total Utilizing Beneficiaries	Total Paid Claims
59148000713	ARIPIRAZOLE	ABILIFY 5 MG TABLET	\$103,018,921	27,901	102,889
59148000813	ARIPIRAZOLE	ABILIFY 10 MG TABLET	\$88,778,806	24,480	90,723
47781030301	NITROFURANTOIN MONOHD/M-CRYST	NITROFURANTOIN MONO-MCR 100 MG	\$426,528	21,134	23,192
59148000913	ARIPIRAZOLE	ABILIFY 15 MG TABLET	\$52,347,444	13,420	55,177
51285010088	LEVONORGESTREL	TAKE ACTION 1.5 MG TABLET	\$560,685	12,717	16,787
59148000613	ARIPIRAZOLE	ABILIFY 2 MG TABLET	\$41,388,552	11,131	40,095
59148001013	ARIPIRAZOLE	ABILIFY 20 MG TABLET	\$56,531,920	9,535	42,956
00135057603	FLUTICASONE PROPIONATE	FLONASE ALLERGY RLF 50 MCG SPR	\$332,190	9,065	12,569
00186504031	ESOMEPRAZOLE MAGNESIUM	NEXIUM DR 40 MG CAPSULE	\$5,918,411	7,802	18,424
68682045570	METRONIDAZOLE	METRONIDAZOLE VAGINAL 0.75% GL	\$944,660	6,893	7,406

APPENDIX B: Definition of terms.

Adjudicate: To pay or deny drug claims after evaluating the claim for coverage requirements

Beneficiary: A person who has been determined eligible for Medi-Cal, as according to the California Code of Regulations 50024

Eligible beneficiary: A Medi-Cal beneficiary that qualifies for drug benefits

Quarter: One fourth, $\frac{1}{4}$, 25% or .25 of a year measured in months.

Reimbursement: The reimbursement paid to Medi-Cal pharmacy providers for legend and nonlegend drugs dispensed to Medi-Cal Fee-for-Service (FFS) beneficiaries. Reimbursement is determined in accordance with CA Welfare and Institutions Code Section 14105.45(b)(1).

Drug therapeutic category: Drug therapeutic categories are grouping of drugs at various hierarchy levels and characteristics that may be similar in chemical structure, pharmacological effect, clinical use, indications, and/or other characteristics of drug products.

Utilizing beneficiary: A Medi-Cal beneficiary with at least one prescription filled during the measurement period



MEDI-CAL FFS PHYSICIAN-ADMINISTERED DRUGS 2nd QUARTER 2018

Utilization of physician-administered drugs in the Medi-Cal Fee-for-Service program during the second quarter of 2018 (April – June 2018) is presented below, stratified by category. In order to show changes in utilization over time, **Table 1** shows the comparison to the prior quarter (2018 Q1) and **Table 2** shows the comparison to the prior-year quarter (2017 Q2).

Category	Total Utilizing Beneficiaries	% Change from 2018 Q1	Total Paid Claims	% Change from 2018 Q1	Total Reimbursement Dollars Paid	% Change from 2018 Q1
PHYSICIAN ADMINISTERED DRUG - NDC NOT REQUIRED (vaccines, hyaluronate)*	49,996	-22.5%	140,313	-20.4%	\$2,069,728	-15.2%
PHYSICIAN ADMINISTERED DRUG - NDC REQUIRED	239,313	-5.7%	573,510	-2.8%	\$69,769,958	-7.1%
MISCELLANEOUS PRODUCT - REPORTING REQUIRED (supplies, immune globulin, IV solutions)	113,163	-8.0%	217,247	-8.1%	\$2,418,071	-10.5%
TOTAL	402,472	-8.8%	931,070	-7.2%	\$74,257,758	-7.5%

Category	Total Utilizing Beneficiaries	% Change from 2017 Q2	Total Paid Claims	% Change from 2017 Q2	Total Reimbursement Dollars Paid	% Change from 2017 Q2
PHYSICIAN ADMINISTERED DRUG - NDC NOT REQUIRED (vaccines, hyaluronate)*	49,996	185.2%	140,313	432.3%	\$2,069,728	147.3%
PHYSICIAN ADMINISTERED DRUG - NDC REQUIRED	239,313	-10.2%	573,510	-8.7%	\$69,769,958	-1.7%
MISCELLANEOUS PRODUCT - REPORTING REQUIRED (supplies, immune globulin, IV solutions)	113,163	-4.8%	217,247	-4.0%	\$2,418,071	-6.6%
TOTAL	402,472	-0.1%	931,070	5.7%	\$74,257,758	-0.2%

*Effective July 1, 2017, Child Health and Disability Prevention (CHDP) claims processing officially transitioned to HIPAA compliant billing formats, including a change where providers are required to enter modifier SL (state-supplied vaccine) on vaccines supplied by the Vaccines for Children (VFC) program. While providers billing VFC procedure codes are reimbursed for vaccine administration costs only, these claims appear in the quarterly PADs data starting with 2017 Q3.

The following three tables show the top 20 physician-administered drugs by total utilizing beneficiaries (**Table 3**), total reimbursement dollars paid (**Table 4**), and reimbursement paid per utilizing beneficiary (**Table 5**). Each table has the comparison to the prior quarter and the prior-year quarter, for reference. In addition, the prior-year ranking is given to show changes in utilization of a drug over time.

Table 3: Top 20 Physician-Administered Drugs by Total Utilizing Beneficiaries

Rank	Last Year Rank	HCPCS Code	Drug Description	2018 Q2 Total Utilizing Beneficiaries	% Change Total Utilizing Beneficiaries from 2018 Q1	% Change Total Utilizing Beneficiaries from 2017 Q2	2018 Q2 Total Reimbursement Dollars Paid	2018 Q2 Total Paid Claims
1	1	J3490	MEDROXYPROGES TERONE ACETATE	37,023	-3.3%	-6.7%	\$2,919,677	37,989
2	2	J3490	LEVONORGESTREL	26,805	-11.4%	-13.6%	\$597,804	28,093
3	54	90670	PCV13 VACCINE IM*	22,293	-13.8%	1020.3%	\$240,227	23,630
4	5	J1885	KETOROLAC TROMETHAMINE	17,834	-2.4%	-1.8%	\$101,001	19,618
5	4	S4993	LEVONORGESTREL-ETHIN ESTRADIOL	17,136	-7.3%	-12.3%	\$2,087,205	17,531
6	3	J2405	ONDANSETRON HCL/PF	15,500	-8.7%	-29.4%	\$77,756	18,144
7	104	90680	RV5 VACC 3 DOSE LIVE ORAL*	13,351	-14.5%	1714.0%	\$173,181	14,559
8	8	Z7610	ACETAMINOPHEN	12,579	-21.5%	11.4%	\$97,663	14,892
9	101	90744	HEPB VACC 3 DOSE PED/ADOL IM*	10,803	-13.2%	1357.9%	\$98,563	11,001
10	6	Q9967	LOCM 300399MG/ML IODINE,1ML	10,787	-4.2%	-16.7%	\$49,332	11,510
11	9	Q0144	AZITHROMYCIN	10,529	-3.5%	-4.5%	\$222,804	11,020
12	10	J0696	CEFTRIAZONE SODIUM	10,477	-9.5%	-0.5%	\$63,477	11,336
13	7	J3490	ULIPRISTAL ACETATE	10,238	-4.4%	-19.7%	\$286,440	10,915
14	14	90715	TDAP VACCINE >7 IM*	10,016	3.0%	17.8%	\$258,799	10,094
15	73	90698	DTAP-IPV/HIB VACCINE IM*	9,523	-12.7%	664.9%	\$90,883	10,193
16	94	90648	HIB PRP-T VACCINE 4 DOSE IM*	9,431	-12.7%	1075.9%	\$89,033	9,874
17	11	J7307	ETONOGESTREL	9,393	-6.0%	-4.3%	\$7,285,110	9,393
18	15	Z7610	IBUPROFEN	9,141	-16.0%	11.1%	\$67,422	9,664
19	12	S4993	NORGESTIMATE-ETHINYL ESTRADIOL	7,528	-11.7%	-22.7%	\$746,681	7,787
20	145	90633	HEPA VACC PED/ADOL 2 DOSE IM*	7,276	-10.3%	1397.1%	\$65,395	7,296

*Effective July 1, 2017, Child Health and Disability Prevention (CHDP) claims processing officially transitioned to HIPAA compliant billing formats, including a change where providers are required to enter modifier SL (state-supplied vaccine) on vaccines supplied by the Vaccines for Children (VFC) program. While providers billing VFC procedure codes are reimbursed for vaccine administration costs only, these claims appear in the quarterly PADs data starting with 2017 Q3.

Table 4: Top 20 Physician-Administered Drugs by *Total Reimbursement Dollars Paid*

Rank	Last Year Rank	HCPCS Code	Drug Description	2018 Q2 Total Reimbursement Dollars Paid	% Change Total Reimbursement Dollars from 2018 Q1	% Change Total Reimbursement Dollars from 2017 Q2	2018 Q2 Total Utilizing Beneficiaries*	2018 Q2 Total Paid Claims
1	1	J7307	ETONOGESTREL	\$7,285,110	-5.4%	-2.9%	9,393	9,393
2	N/A	J1428	ETEPLIRSEN	\$4,739,962	104.0%	N/A ²	21	347
3	3	J7298	LEVONORGESTREL ¹	\$3,047,388	1.5%	-10.9%	4,137	4,138
4	4	J3490	MEDROXYPROGESTERONE ACETATE	\$2,919,677	-1.3%	-0.4%	37,023	37,989
5	7	J1745	INFLIXIMAB	\$2,692,854	5.0%	11.1%	552	1,104
6	10	J9019	ASPARAGINASE (ERWINIA CHRYSAN)	\$2,580,830	55.5%	9.7%	36	269
7	5	J9355	TRASTUZUMAB	\$2,476,854	0.1%	-9.5%	232	784
8	2	J7189	COAGULATION FACTOR VIIA, RECOMB (NOVOSEVEN®)	\$2,454,531	-57.1%	-51.0%	33	122
9	6	Q4081	EPOETIN ALFA (100 UNITS ESRD)	\$2,368,867	3.3%	-9.5%	1,908	44,498
10	8	J7300	COPPER INTRAUTERINE DEVICE	\$2,117,187	-4.5%	-12.2%	3,110	3,134
11	9	S4993	LEVONORGESTREL-ETHIN ESTRADIOL	\$2,087,205	-7.4%	-12.1%	17,136	17,531
12	11	J2505	PEGFILGRASTIM	\$2,007,643	13.4%	4.9%	271	565
13	13	J7304	NORELGESTROMIN/ETHIN. ESTRADIOL	\$1,872,250	2.9%	3.0%	2,988	3,070
14	12	J1300	ECULIZUMAB	\$1,667,489	-17.1%	-8.5%	27	135
15	14	J7192	ANTIHEMOPH.FVIII, FULL LENGTH (INCLUDES ADVATE®, HELIXATE®, AND KOGENATE®)	\$1,535,078	-24.4%	-11.4%	46	178
16	15	J9306	PERTUZUMAB	\$1,446,485	27.4%	1.1%	118	1,126
17	17	J9035	BEVACIZUMAB	\$1,019,715	-4.3%	-14.9%	422	850
18	20	J1743	IDURSULFASE	\$992,199	-5.5%	4.2%	< 20	120
19	16	J7301	LEVONORGESTREL	\$867,085	-18.0%	-29.5%	1,193	1,195
20	27	J7205	ANTIHEMOPH.FVIII REC, FC FUSION (ELOCTATE®)	\$812,003	-14.7%	28.2%	20	67

*Cells with numbers less than 20 have been changed for privacy

¹Effective for dates of service on or after October 1, 2017, HCPCS codes J7297 (levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration) and J7298 (levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration) are benefits. Further, effective for dates of service on or after October 1, 2017, HCPCS code J7302 (levonorgestrel-releasing intrauterine contraceptive system, 52 mg) is no longer reimbursable.

²There were no utilizing beneficiaries in 2017 Q2.

Table 5: Top 20 Physician-Administered Drugs by *Reimbursement Paid per Utilizing Beneficiary*

Rank	Last Year Rank	HCPCS Code	Drug Description	2018 Q2 Reimbursement Dollars Paid per Utilizing Beneficiary	% Change Reimbursement Dollars Paid per Utilizing Beneficiary from 2018 Q1	% Change Reimbursement Dollars Paid per Utilizing Beneficiary from 2017 Q2	2018 Q2 Total Paid Claims*	2018 Q2 Total Utilizing Beneficiaries*
1	N/A	J1428	ETEPLIRSEN	\$225,712	94.3%	N/A ⁵	347	21
2	1	J1322	ELOSULFASE ALFA	\$144,145	11.0%	-4.8%	60	< 20
3	2	J7181	FACTOR XIII A-SUBUNIT, RECOMB (TRETTE®)	\$138,099	35.9%	0.5%	< 20	< 20
4	5	J7202	FACTOR IX RECOM, ALBUMIN FUSION (IDELVION®) ¹	\$105,484	13.9%	7.3%	24	< 20
5	N/A	J2326	NUSINERSEN SODIUM/PF	\$96,000	N/A ⁴	N/A ⁵	< 20	< 20
6	3	J1458	GALSULFASE	\$94,118	-21.9%	-15.4%	67	< 20
7	6	J1743	IDURSULFASE	\$82,683	-13.4%	-13.1%	120	< 20
8	9	J7201	FACTOR IX REC, FC FUSION PROTN (ALPROLIX®)	\$75,587	-12.3%	-1.8%	< 20	< 20
9	4	J7189	COAGULATION FACTOR VIIA, RECOMB (NOVOSEVEN®)	\$74,380	-40.2%	-30.3%	122	33
10	76	J7194	FACTOR IX CPLX(PCC)NO4,3FACTOR (PROFILNINE®)	\$72,960	N/A ⁴	2689.0%	< 20	< 20
11	8	J9019	ASPARAGINASE (ERWINIA CHRYSAN)	\$71,690	33.9%	-11.6%	269	36
12	10	J1300	ECULIZUMAB	\$61,759	-17.1%	-11.9%	135	27
13	N/A	C9014	CERLIPONASE ALFA	\$57,309	-29.2%	N/A ⁵	75	< 20
14	24	J7195	FACTOR IX HUMAN RECOMBINANT (BENEFIX®)	\$48,439	0.9%	83.5%	< 20	< 20
15	N/A	C9028	INOTUZUMAB OZOGAMICIN	\$47,184	-45.4%	N/A ⁵	< 20	< 20
16	14	J0180	AGALSIDASE BETA	\$46,237	9.9%	-12.1%	56	< 20
17	15	J7205	ANTIHEMOPH.FVIII REC, FC FUSION (ELOCTATE®) ²	\$40,600	-36.0%	-3.9%	67	20
18	11	J7207	ANTIHEMO.FVIII, FULL LENGTH PEG (ADYNOVATE®) ³	\$36,328	-28.6%	-46.7%	22	< 20
19	23	J7192	ANTIHEMOPH.FVIII, FULL LENGTH (INCLUDES ADVATE®, HELIXATE®, AND KOGENATE®)	\$33,371	-1.4%	2.1%	178	46
20	N/A	J9301	OBINUTUZUMAB	\$33,057	N/A ⁴	N/A ⁵	< 20	< 20

*Cells with numbers less than 20 have been changed for privacy

¹Code J7202 was effective January 1, 2018, however code J7199 was still accepted for this drug for part of 2018 Q1.

²Code J7205 was effective October 1, 2017, replacing code Q9975.

³Code J7207 was effective January 1, 2018, however code C9137 was still accepted for this drug for part of 2018 Q1.

⁴There were no utilizing beneficiaries in 2018 Q1.

⁵There were no utilizing beneficiaries in 2017 Q2.

DUR Publications: Q3 2018

Shal Lynch, PharmD, CGP
Health Sciences Associate Clinical Professor
Department of Clinical Pharmacy
School of Pharmacy

DUR Publications

September 2018

- Alert – [Mandatory Use of CURES 2.0 Begins October 2, 2018](#)
- Bulletin – [2018 Immunization Updates: Flu, Tdap, HepB, Zoster, MMR, Adult Vaccines](#)

Future Recommendations

- Alerts:
 - California Upgrades Immunization Registry to CAIR2
- Bulletins:
 - Latent tuberculosis infection (scheduled for December publication)
 - Managing pain in population with comorbid mental health conditions
 - Pharmacist furnishing of naloxone
 - Pharmacist furnishing of hormonal contraception
 - Hypertension medication adherence
 - Topics from today's meeting: new additions during FFY 2017, HCV treatment

Board recommendations?

Prospective DUR Updates: Q3 2018

Amanda R. Fingado, MPH
Senior Epidemiologist/Statistician
Department of Clinical Pharmacy

Prospective DUR Updates – Q3 2018

Topics for Discussion:

- New Generic Code Number (GCN) Alert Profiles
- Therapeutic Duplication (TD) Alert

New GCN Alert Profiles

Background

- Each week new Generic Code Numbers (GCNs) are added
- Overutilization (ER), Drug-Pregnancy (PG) and Drug-Drug Interactions (DD) alerts are automatically turned on for all new GCNs
- New GCNs are reviewed weekly for additional alerts
- New GCNs with alerts turned on other than ER, PG, and DD are provided at each Board meeting for review

New GCN Alert Profiles (cont.)

Table 1. New GCNs for Existing DUR Target Drugs: Q3 2018

GCN(s)	Drug Description	Alerts Turned on
078588	ARIPRAZOLE LAUROXIL, SUBMICR.	MC, TD, LR, AT, ID, HD, LD
078660	BUTALBITAL/ACETAMINOPHEN	AT, ID, HD
078617	CELECOXIB/CAPSAI/M-SAL/MENTHOL	HD, LD
078957	CHLORPHENIRAMINE/PE/CODEINE	ID
077819	DARUNAVIR/COB/EMTRI/TENOF ALAF	ID
078611, 078619	DICLOFEN SOD/CAPSAI/M-SAL/MENT	DA, MC, TD, ID, HD, LD
078630	DICLOFENAC SODIUM	DA, MC, TD, ID, HD, LD
078775	DICLOFENAC/LIDOCAINE/TAPE	DA, MC, TD, ID, HD, LD
078822	DORAVIRINE/LAMIVU/TENOFOV DISO	ID
078644	GABAPENTIN	DA, LR, ID, HD, LD
078838	HYDROMORPHONE HCL IN WATER/PF	AT
078551, 078549	HYDROMORPHONE HCL/PF	AT
078616	IBUPROFEN/CAPSAI/M-SAL/MENTHOL	DA, HD, LD
078119 - 078122	METOPROLOL SUCCINATE	MC, TD, LR, HD, LD
078565	MIDAZOLAM/KETAMINE/ONDANSETRON	AT
078811	MORPHINE SULFATE IN 0.9 % NACL	DA, MC, TD, AT, ID, HD, LD
078814	NIFEDIPINE, MICRONIZED	MC, TD, LR, ID, HD, LD
078604, 078605	PIMAVANSERIN TARTRATE	MC, TD, LR, AT, ID, HD, LD
078821	POTASSIUM CHLORIDE IN WATER	MC, TD, ID, HD, LD
078740, 078741	RISPERIDONE	MC, TD, LR, AT, ID, HD, LD
078895, 078896	SOD, POT CHLOR/SOD CIT/RICE SYR	MC, TD, ID, HD, LD



Board questions/recommendations?

5 Prospective DUR Update – 2018Q3 (7/1/18 – 9/30/18)



Therapeutic Duplication (TD) Alert



- In Q3 2017 the ingredient duplication (ID) alert for all formulations of quetiapine was turned off, based on Board recommendations
 - Consistent with clinical guidelines
 - At the time it was the top alert-drug combination by alert volume
- Also during Q3 2017... the Medi-Cal FFS program upgraded the therapeutic duplication (TD) alert to the Duplicate Therapy Module™ from First Databank, Inc. (FDB)
 - Allowed drugs to be compared across drug therapeutic categories

6 Prospective DUR Update – 2018Q3 (7/1/18 – 9/30/18)



TD Alert: Report Findings



- The Q3 2017 DUR Report showed the following:
 - ID-quetiapine no longer the top alert-drug combination (by alert volume)
 - TD-quetiapine was now the top alert-drug combination
 - There was a 54% increase in TD alerts compared to the prior quarter, attributed mainly to the upgrade now looking across categories
 - Aripiprazole, for example, had previously generated no TD alerts due to being classified in a different category from the other atypical antipsychotics

TD Alert: Example



On 2/1/18 a patient tried to fill a prescription for RISPERIDONE. Patient has active paid claims in medication history for QUETIAPINE (last paid claim 1/1/18) and ARIPIPRAZOLE (last paid claim 1/15/18).

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ Before Upgrade (2 alerts): <ul style="list-style-type: none"> - RISPERIDONE claim generates a TD alert for QUETIAPINE - The next claim for QUETIAPINE would generate a TD alert for RISPERIDONE - The next claim for ARIPIPRAZOLE would generate no TD alerts | <ul style="list-style-type: none"> ▪ After Upgrade (6 alerts): <ul style="list-style-type: none"> - RISPERIDONE claim generates a TD alert for TD with QUETIAPINE and a second TD alert for ARIPIPRAZOLE - The next claim for QUETIAPINE would generate a TD alert for RISPERIDONE and a second TD alert for ARIPIPRAZOLE - The next claim for ARIPIPRAZOLE would generate a TD alert for RISPERIDONE and a second TD alert for QUETIAPINE |
|---|---|

TD Alert: Discovery!



- While preparing a report for this meeting on the top TD alert-drug combinations, we found more than half of TD alerts for quetiapine were just for other formulations of quetiapine
- Subsequent investigation into this found the following:
 - The ID alert generated for two different formulations of quetiapine overrode the TD alert generated for having two drugs in an “antipsychotic” category
 - When the ID alert was turned off, it was no longer available to override the TD alert

TD Alert: Update



- Confirmed: the same thing happened with lithium
 - All non-300 mg formulations began generating TD alerts for other formulations of lithium because the ID alerts had been turned off
 - All 300 mg formulations of lithium generated no TD alerts (because the ID alerts overrode the TD alerts)
- Currently working on a solution
- Will update the Board with progress at the next meeting
- Silver lining: TD alert problem isn't quite as bad as we thought



Board questions/recommendations?

DUR Educational Outreach: Q3 2018

Amanda R. Fingado, MPH
Senior Epidemiologist/Statistician
Department of Clinical Pharmacy

Outcomes: MEDD 2018 - 1

Background:

- In 2016, DUR program sent letters/profiles to 134 prescribers of 155 beneficiaries with individual paid claims > 120 mg MEDD
- Outcomes:
 - Response rate 23% with 97% rating info as “useful” or “very useful”
 - 40% of beneficiaries ↓ total days with cumulative MEDD > 120 mg
 - 20% of beneficiaries ≥1 paid claim for MAT
- In November 2017 the Board recommended repeat of mailing

Outcomes: MEDD 2018 - 2



Objectives:

- To improve the quality of pain treatment among non-cancer, non-hospice Medi-Cal fee-for-service beneficiaries at increased risk of opioid overdose.

Outcomes: MEDD 2018 - 3



Methods:

- Study population included 200 continuously-eligible non-cancer, non-hospice Medi-Cal fee-for-service beneficiaries with at least 1 paid claim > 120 mg MEDD
 - Beneficiaries selected based on additional risk factors including concomitant CNS depressant use, medical claims history
- Letters included patient profiles, Medi-Cal DUR MEDD article, handout on naloxone, and provider response survey
- Letters mailed to 254 prescribers on November 16, 2018

Outcomes: MEDD 2018 - 4



Outcomes:

- Primary outcome
 - The percentage of the continuously-eligible study population with a paid claim exceeding > 120 mg MEDD in the 6-month period following the mailing of the intervention letter

Outcomes: MEDD 2018 - 5



Outcomes:

- Secondary outcomes
 - % of the continuously-eligible study population with at least 1 paid claim for MAT in the 6-month period following the mailing
 - % of the continuously-eligible study population with hospital or emergency department visits due to opioid overdose in the 6-month period following the mailing
 - % of the continuously-eligible study population with at least 1 paid claim for naloxone in the 6-month period following the mailing



Board recommendations?

Next Board Meeting

February 2019

- Proposal: LTBI
- Outcomes: Additive Toxicity

Future Topics



DUR Educational Outreach to Pharmacies/Providers

- Over-the-Counter Medications
- QT Prolongation
- Late Refill

Board recommendations?





Global Medi-Cal Drug Utilization Review Board Meeting Pharmacy Updates

Pauline Chan, R.Ph., MBA
Pharmacy Operations Branch
11-27-18



Reflection

"The program shall focus on medication therapies with the broad goals of improving patient outcomes, increasing the quality of prescribing practice, reducing healthcare costs, and improving beneficiary, prescriber and pharmacist satisfaction."

Global Medi-Cal DUR Bylaws, 2017



Medi-Cal DUR Board Meeting 11-27-18



Topics

- Prescription Drug Overdose Prevention Initiative
- Smart Care California
- Naloxone
- Drug Take-Back Service
- Six building blocks
- Million Hearts 2022
- Medi-Cal Populations
- CMS DUR Annual Report 2018



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Prescription Drug Overdose Prevention Initiative

- Statewide Overarching Strategy:
 1. Safe Prescribing
 2. Access to Treatment
 3. Naloxone distribution
 4. Public Education Campaign
 5. Data Informed/Driven Intervention



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Prescription Drug Overdose Prevention Initiative-2

- Overarching strategies to achieve following 5 measures:
 - Increase number of active buprenorphine prescribers
 - Increase number of naloxone claims
 - Decrease all cause overdose mortality
 - Less use of concurrent benzos and opioids
 - Less use of opioids >MEDD 90mg



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Smart Care California

- Health plan and purchaser checklist
 - Four priority areas
 - Prevent new starts
 - Manage pain safely
 - Treat addiction
 - Stop deaths



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Smart Care California - 2

- Medi-Cal Plans
 - Progress made in all four priorities
 - Within each priority, approaches with strongest evidence for impact were reported as 1) in place, 2) in planning, 3) no plans
 - Highest % of action plan “in place”
 - Co-prescribing Naloxone -75.0%
 - Buprenorphine waiver training – 68.8%
 - Naloxone member education – 62.5%
 - Implement quantity limits – 50.0%
 - Primary care addiction treatment (buprenorphine/naltrexone) – 43.8%



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Naloxone

Resources available from California State Board of Pharmacy:

- Training requirement for pharmacists to furnish naloxone to patients without a prescription (no-cost webinar)
- Recently revised training guide: “Opioid Safety: Focus on Furnishing Naloxone – A Guide for California Community Pharmacists”

[Focus on Furnishing Naloxone](#)



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Drug Take-Back Services

- For consumers to safely dispose of unwanted or expired prescription drugs
- Drug take-back pharmacies are registered with the California State Board of Pharmacy
 - On-site collection bins
 - Envelopes for mailing back medications
 - Not accepting auto-injectors such as EpiPens and other sharps and needles

[Drug Take-Back Services](#)



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Six Building Blocks Project

- [CDC Six Building Blocks](#)
 - Agency for Health Research & Quality (AHRQ)
 - Quality Improvement
 - Evidence-based
 - Guideline driven care



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Million Hearts 2022

- Million Hearts 2012-2017 Reports
 - [Million Hearts Update](#)
 - [MMWR](#)
- Million Hearts 2022
 - To achieve 80% or greater performance of ABCS*
 - At least 20% reduction in physical inactivity, tobacco use and sodium consumption

*ABCS=appropriate aspirin use, blood pressure control, cholesterol control, and smoking cessation



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Medi-Cal Populations

- [Medi-Cal at a Glance](#)
 - Delivery system
 - Gender
 - Age
 - Aid categories
 - Race/ethnicity
 - Primary language



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CMS DUR Annual Report 2018

- [CMS-R-153](#)
- 2018 report to present to DUR board in May 2019
- 2018 report due CMS 6/30/2019
- Annual DUR Report to include FFS and each Medi-Cal MCO with:
 - MCO Survey questionnaires
 - Educational outreach summary
 - Generic substitution policy and utilization data (single source, non-innovator multiple-source, innovator-multiple source) claims and %
 - Innovative practice
 - E-prescribing activities



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QUESTIONS

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